

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 6 1 9 3					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR					
George L. Alexander				October 17, 1980				5:45 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS			
Male		White		Dec. 10, 1895		84 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Harford MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Harford				Harford Mem. Hospital				Freight Conductor				PennRR	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Cecil		Perryville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		524 Arch Street			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John Alexander				ANNA Frederick									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				716-01-7871		Russell Burroughs, Perryville, Maryland.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 1533													
DUE TO, OR AS A CONSEQUENCE OF (b) colon obstruction of ileum +													
DUE TO, OR AS A CONSEQUENCE OF (c) invasion of the int. squel. vessel													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/29, 1980, to 10/17, 1980, that (I) (we) lost saw the deceased alive on 10-17-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
V.R. CARABUR										10/17/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
V.R. CARABUR				HPG									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial				Oct 20, 1980		Asbury Cemetery		Pott Deposit, Cecil, Maryland.					
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR					
Lee A. Patterson & Son				Perryville, Maryland.				OCT 22 1980					

1911

Annual Report

1911-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 0 2 6 1 9 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) JAMES ISAAC BAIN					2a. DATE OF DEATH MONTH DAY YEAR October 27, 1980			2b. HOUR 11:25p	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 8, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. CITY OR TOWN Washington					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2301 11th. Street, N.W.		
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 578-18-2933		17. INFORMANT ADDRESS Ellen M. Bain - Wife SAA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Seizure Disorder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (if this hospital) attended the deceased from 9-29 19 80 , to 10-27 19 80 , that (if) (we) last saw the deceased alive on 10-27 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Prem Lal, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-27-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, M.D.					22e. ADDRESS VAMC Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/1980		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Ph.		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland			
24. FUNERAL DIRECTOR NAME WM ERNEST GARVIS CO, INC.		ADDRESS 1432 U. ST. N.W. Washington, DC		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE <i>Barry K. Ruddy</i>			



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05/11/11

• *It's Not a Power*

Non-Fossil Fuel

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26195	
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN F. BIXLER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 10 DAY 6 YEAR 1980		2b. HOUR 10:25 AM			
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH MONTH 8 DAY 15 YEAR 1944	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH 10 DAY 6 YEAR 1980		2d. HOUR 10:25 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD					
10. CITY OR TOWN OF DEATH FALLSTON, MD		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LASOREN		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Pa.		13b. COUNTY ADAMS		13c. CITY OR TOWN East Berlin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 375			
14. FATHER'S NAME FIRST JOHN MIDDLE — LAST BIXLER				15. MOTHER'S MAIDEN NAME FIRST ELISA MIDDLE A. LAST REED							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 176-04-6772		17. INFORMANT ADDRESS MURRAY SHANASCOON YORK, PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Willard P Amoss				TITLE (SPECIFY) Asst Dr		MEDICAL EXAMINER		DATE SIGNED 10/6/80			
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss				ADDRESS 2404 Pleasantville Rd. Fallston MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/9/80		23c. NAME OF CEMETERY OR CREMATORY PROSPECT Hill Cem		23d. LOCATION CITY OR TOWN YORK COUNTY YORK STATE PA					
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS ADDRESS 600 MAIN ST DEPT PD				25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

Walter Adolf Brehm

2a. DATE KNOWN
OF DEATH

2b. HOUR

3. SEX

M

4. RACE

6 30 94

86 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE
PRONOUNCED
DEAD

2d. HOUR

7a. BIRTHPLACE
(STATE OR
FOREIGN COUNTRY)

Iowa

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Hartford

10. CITY OR TOWN OF DEATH

Joppa

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

2312 Dunwood Road

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Factory Worker

12b. KIND OF BUSINESS
OR INDUSTRY

Mfg.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Norfolk

13c. CITY OR TOWN

Joppa

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS

2312 Dunwood Rd

14. FATHER'S NAME

Frederick

MIDDLE

--

LAST

Brehm

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

--

LAST

Kargas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

385-16-7688

17. INFORMANT

ADDRESS

Mrs. Bette Chachich, Joppa, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4140

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardio-respiratory Arrest

Arteriosclerotic Heart Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Emphysema

Alcoholism

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

Willard R Amos

M.D.

TITLE (SPECIFY)

MEDICAL EXAMINER

DATE
SIGNED

10/7/80

EXAMINER'S NAME
(TYPE OR PRINT)

Willard R Amos

ADDRESS

2404 Pleasantville Rd, Elbtown, Md

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

Oct. 9, 1980

23c. NAME OF CEMETERY OR CREMATORY

Westview Crematory

23d. LOCATION
CITY OR TOWN

Baltimore

COUNTY

Md.

STATE

24. FUNERAL DIRECTOR

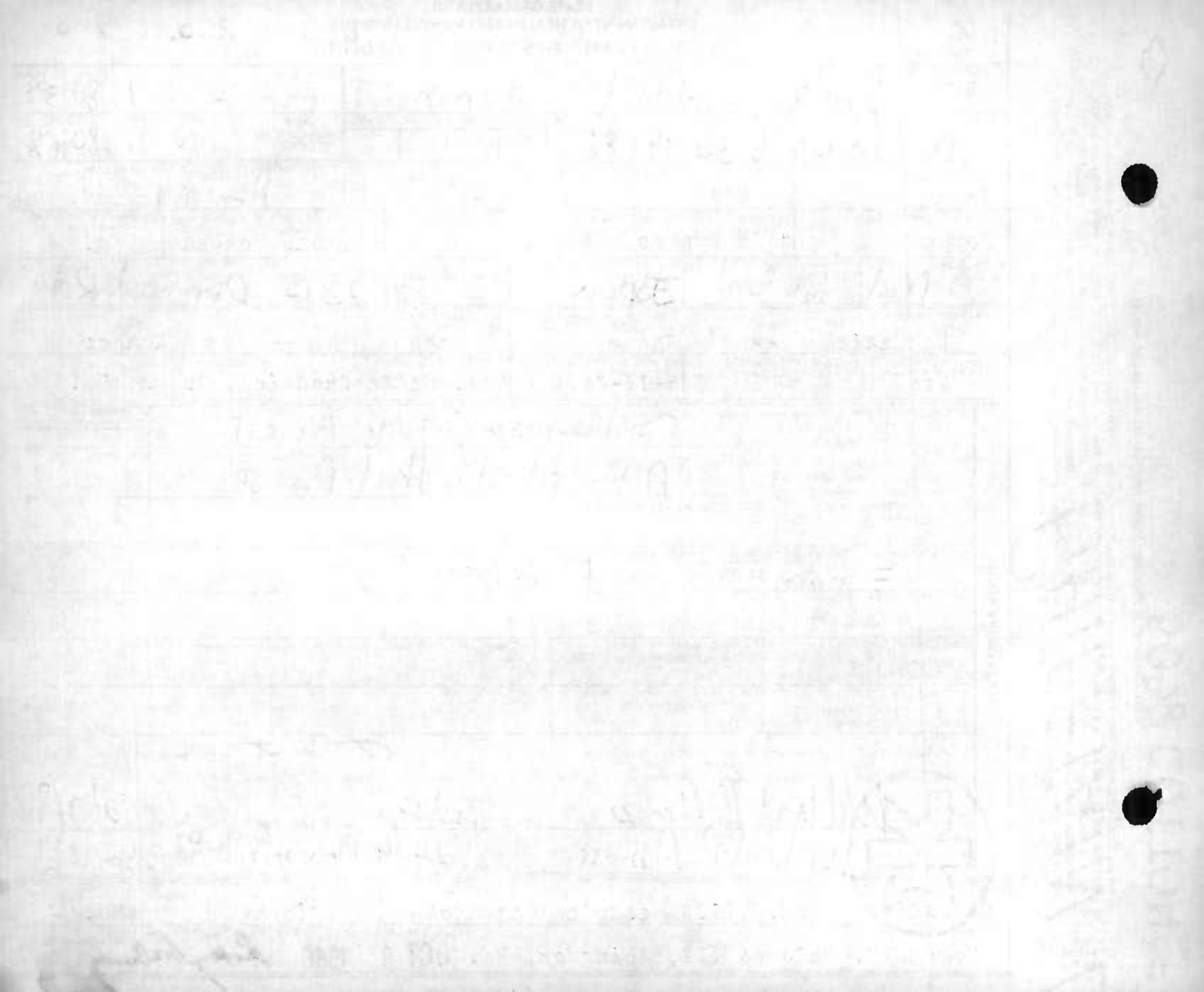
Howard K. McComas III, Abingdon, Md.

25a. DATE REC'D. BY REGISTRAR

OCT 9 1980

25b. REGISTRAR'S SIGNATURE

R. H. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 6 1 9 8	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			REG. NO.		
Blanche Edna BROWN			10 20 80			7:51 P.M.					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
Female		White		08 09 07		73 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina		U.S.A.				Harford MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston General Hosp.				None					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Harford		Fallston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2307 Rutledge Road			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Cicero Levi Brown				Priscilla Blevins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No				217-58-8211		Rachel Brown		same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>										1 min	
4375 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypotension</u>										24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrest</u>										24 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Anoxic cerebral damage</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>10:00-1:30</u> 19 <u>80</u> , to <u>10 Oct</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>30 Oct</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>T.E. Harrison</u>								<u>20 Oct 80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<u>T.E. Harrison</u>				<u>FGM, 700 Milton Ave, Fallston</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY	
Burial		10/23/1980		Centre Cem.		Forest Hill		Harford		MD	
24 FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE RECEIVED BY REGISTRAR		25b. DATE RECEIVED BY REGISTRAR			
M. G. Kurtz III		Jarrettsville, Md.				OCT 23 1980					

10 30 40 121

13
Hartford

08 09 07

Fullerton General Hosp.

Fullerton

21-1-11

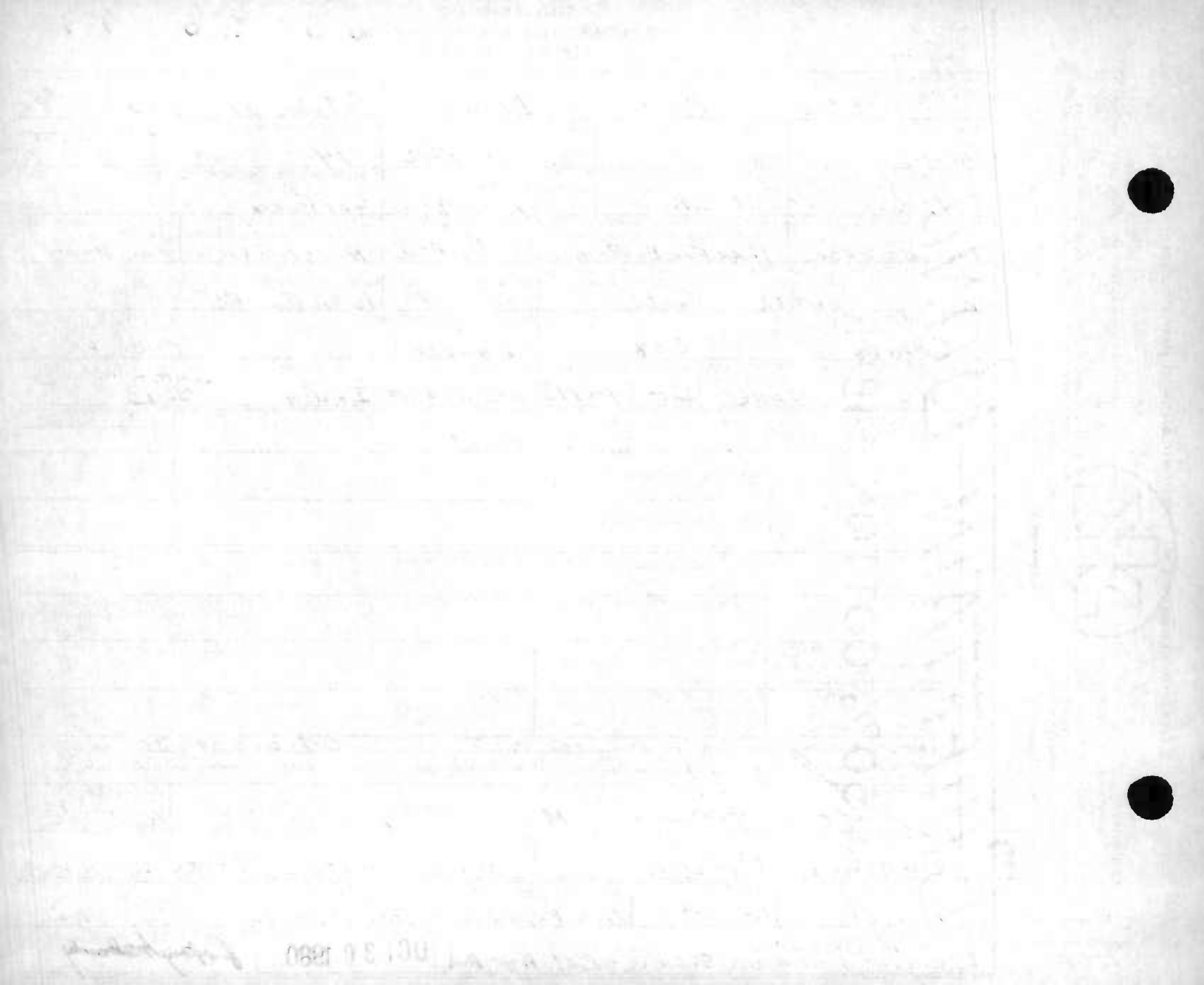
OCT 2 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ellen B. Brown</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>October 28, 1980</i>					2b. HOUR <i>2:40 PM</i>
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>SEPT 14, 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD				
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Fallston</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>16 Mountain Rd</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>CALVIN COX</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ENNACE CROUSE</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>220-34-6173</i>		17. INFORMANT ADDRESS <i>MRS NADINE IRWIN</i>			17b. ADDRESS <i>SAME AS #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery</i> <i>4275</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DO TO, OR AS A CONSEQUENCE OF (b) DO TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 1977</i> , 19____, to <i>October 28, 1980</i> , that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE <i>[Signature]</i> MD								22c. DATE SIGNED <i>10.29.80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gunther Hirsch</i>					22e. ADDRESS <i>So. Union Ave Havre de Grace</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>10-31-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Zion Primitive Baptist</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SPARTA N.C.</i>				
24. FUNERAL DIRECTOR NAME <i>E. BARNES</i>					25a. DATE REC'D. BY REGISTRAR <i>OCT 30 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
26. FLEETING FUNERAL SERVICE - BEL AIR, MD										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

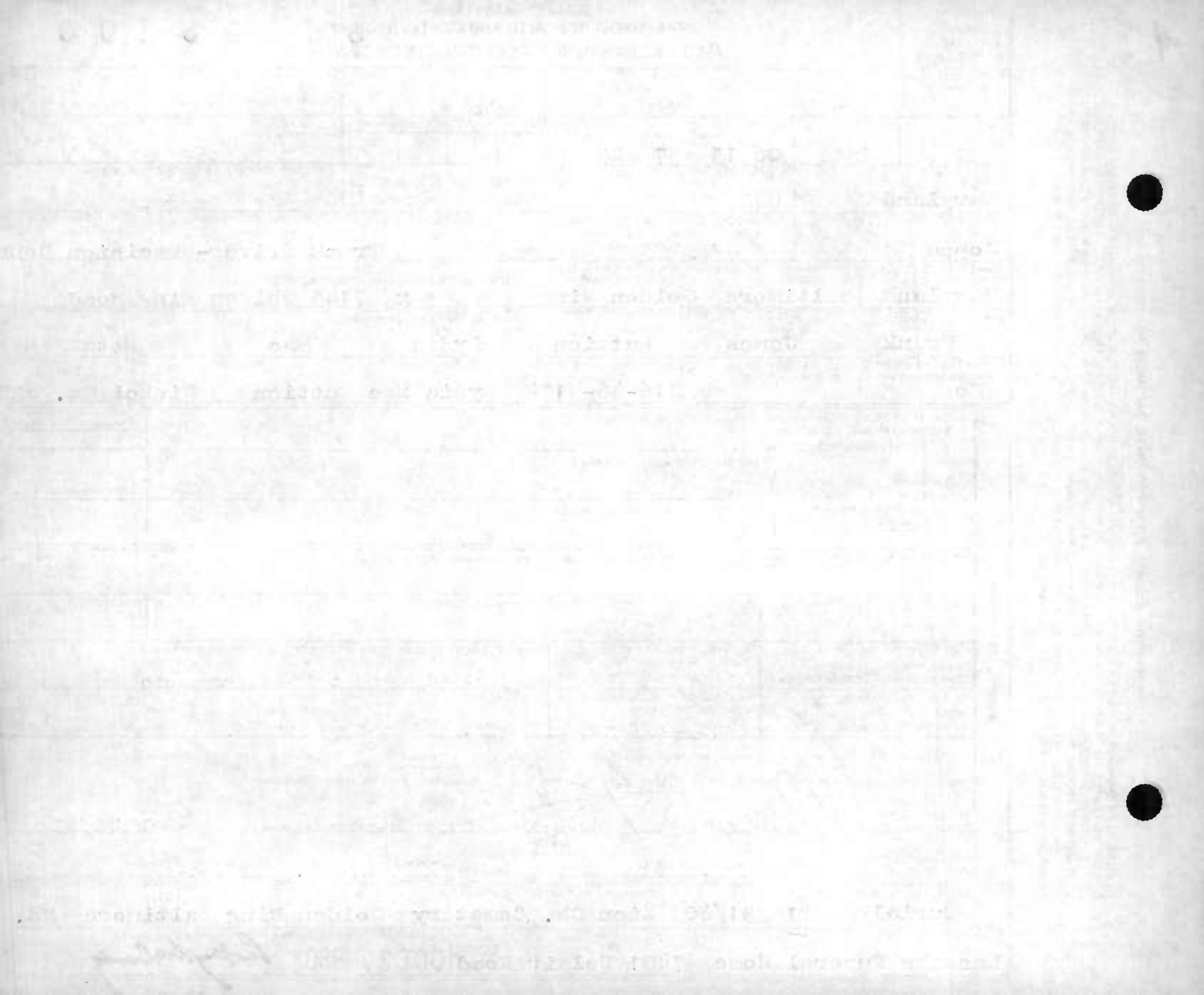
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED				2b. HOUR			
Craig		Steven		Buttton		10 27 80				M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Male	White	06 15 57		23 YRS.						10 28 80				3 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				Harford County, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Joppa		300 Ft. off Winters Run Road						Truck Driver-Precision Conc							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Baltimore		Golden Ring				7145 Golden Ring Road							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Frank James Buttton				Lydia Mae Betz											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No				216-46-9174		Lydia Mae Buttton 3 Winkel Ct. #3D									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				auto - off road				300 ft. off Winters Run Rd. Harford MD.							
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Title (SPECIFY) _____ DATE SIGNED 10/28/80															
ACTUAL SIGNATURE				M.D. Deputy Chief						MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)				Thomas D. Smith, M.D.						ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				10/31/80		Zion Ch. Cemetery				Golden Ring Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lassahn Funeral Home 7401 Belair Road						OCT 30 1980		[Signature]							

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, INDICATE IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

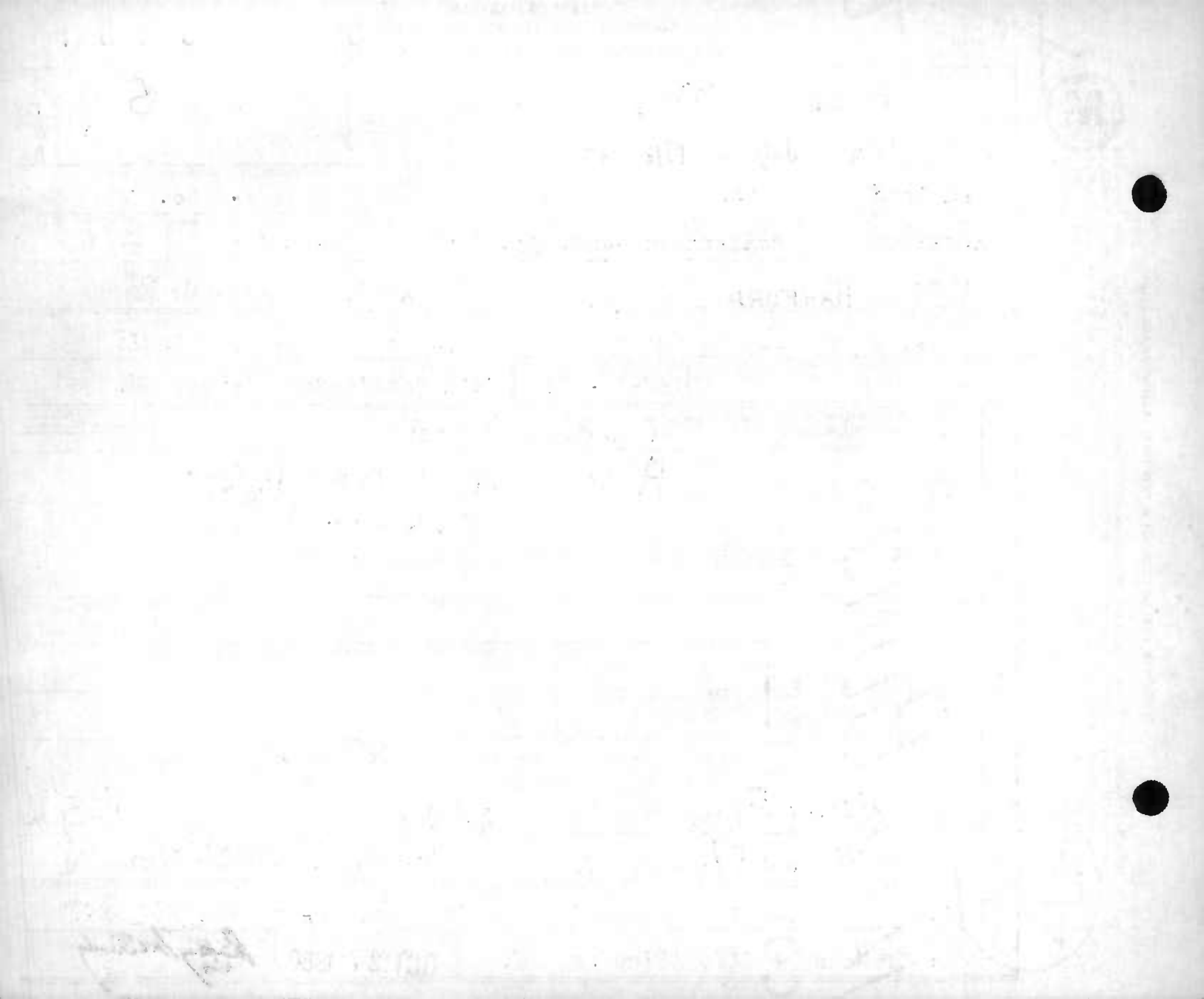
DMMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Elizabeth Mary Carrington								10 25 80								3 ³⁰ AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		2d. HOUR	
Female	Negro	July 3 1916		64 YRS.						10 25 80						9 ⁰⁰ AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
Maryland		USA						Harford County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY											
Joppa		Kaiser Permanente Hospital		Housewife		--											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		HARFORD		Joppa		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1612 Mandeville Rd									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
George -- Evans		Eleanor -- Lewis															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		168-18-0360		John Carrington, Joppa, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4140		Cardiac Arrest				Arteriosclerotic Heart Disease											
						(b)											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c)											
						with Hypertension											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		M.D.		MEDICAL EXAMINER		DATE SIGNED											
Willard P. Amoss		M.D.		2404 Pleasantville Rd		10/25/80											
EXAMINER'S NAME (TYPE OR PRINT)		M.D.		ADDRESS													
Willard P. Amoss		M.D.		2404 Pleasantville Rd		Folton Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		Oct. 29, 1980		Community Baptist Cem.		Joppa Harford Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Howard K. McComas		111, Abingdon, Md.		OCT 27 1980		R. McComas											





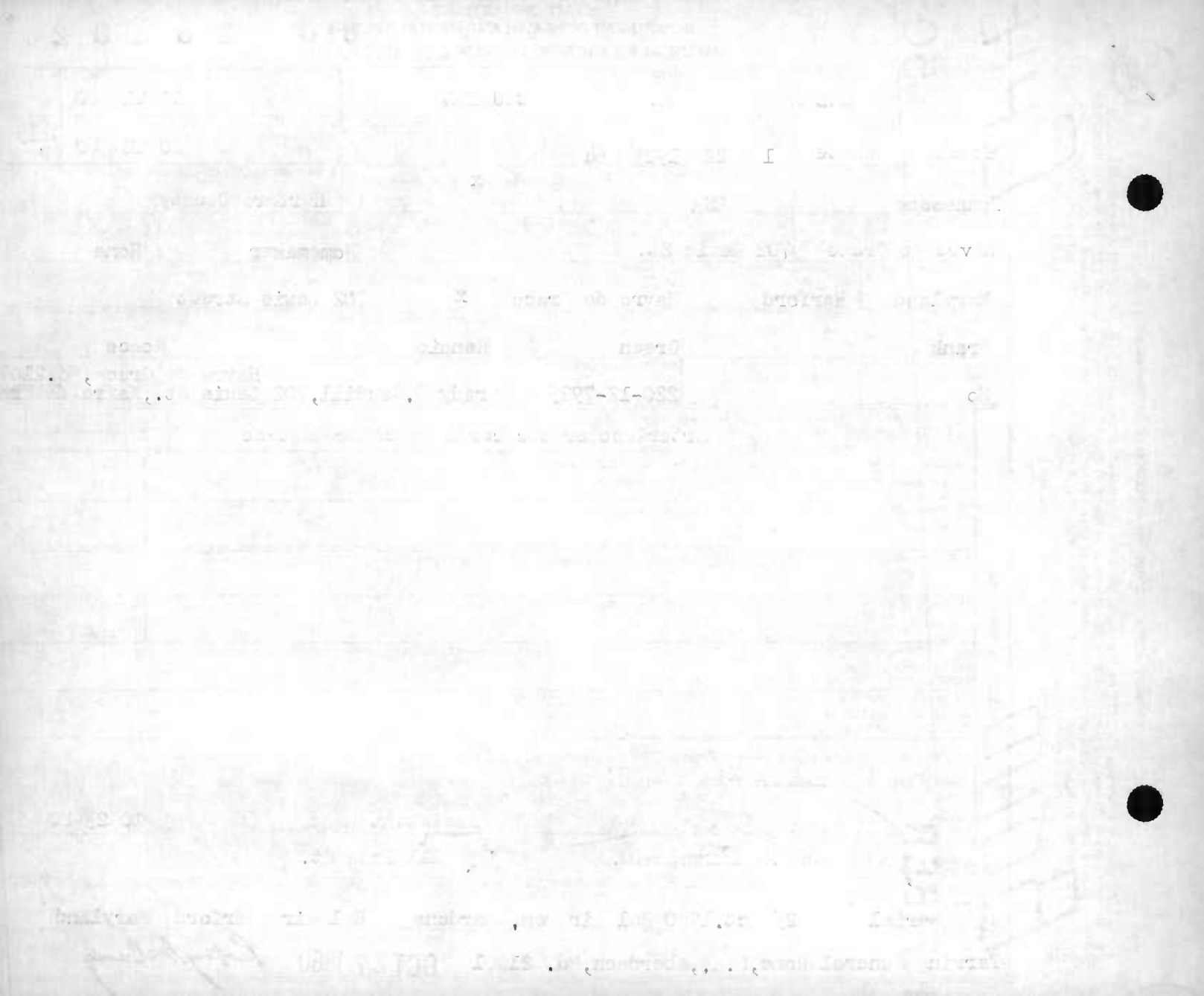
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26202	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL M. CAUDILL						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 22 1980		7b. HOUR 4:15 p			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 22 1925		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 54		IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 22 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 702 Lewis St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 702 Lewis Street		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Green			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rennie Reece								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 220-12-7925			17. INFORMANT Brady B. Caudill					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Ann M. Dixon			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 10-23-80		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 25 Oct. 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001						25a. DATE REC'D. BY REGISTRAR OCT 27 1980			25b. REGISTRAR'S SIGNATURE Robert McCreedy		

BP

DHMH-17
(VFR A15 ME (5))
15M 7/76





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 0 2 6 2 0 3							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert Arthur Cesky					2a. DATE OF DEATH MONTH DAY YEAR October 30, 1980			2b. HOUR 10:05 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 04 01		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel AIR Convalescent Ctr., Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 102 W. Dallam Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Anthony Cesky					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kathryn Warner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-32-0592A		17. INFORMANT (SEE INSTRUCTIONS) ADDRESS Albert Cesky, 102 Dallam Ave., Bel Air 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 7140 DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED RHEUMATOID ARTHRITIS AND DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 3 YRS 3 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-21- 19 69 to 30 OCT 19 80 , that (I) (we) last saw the deceased alive on 29 OCT 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.									
22b. SIGNATURE Harvey Proctor Sidwell, M.D. DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct. 30, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Harvey Proctor Sidwell, M.D.				22e. ADDRESS 401 Franklin St., Bel Air, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1, 1980		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014			
24. FUNERAL DIRECTOR NAME Joseph William Foster				ADDRESS		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE Barney McHenry	

MEDICAL CERTIFICATION

29

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35



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]

[Handwritten signature or initials in the bottom left corner.]

[Handwritten text, possibly a date or reference number, in the bottom center.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

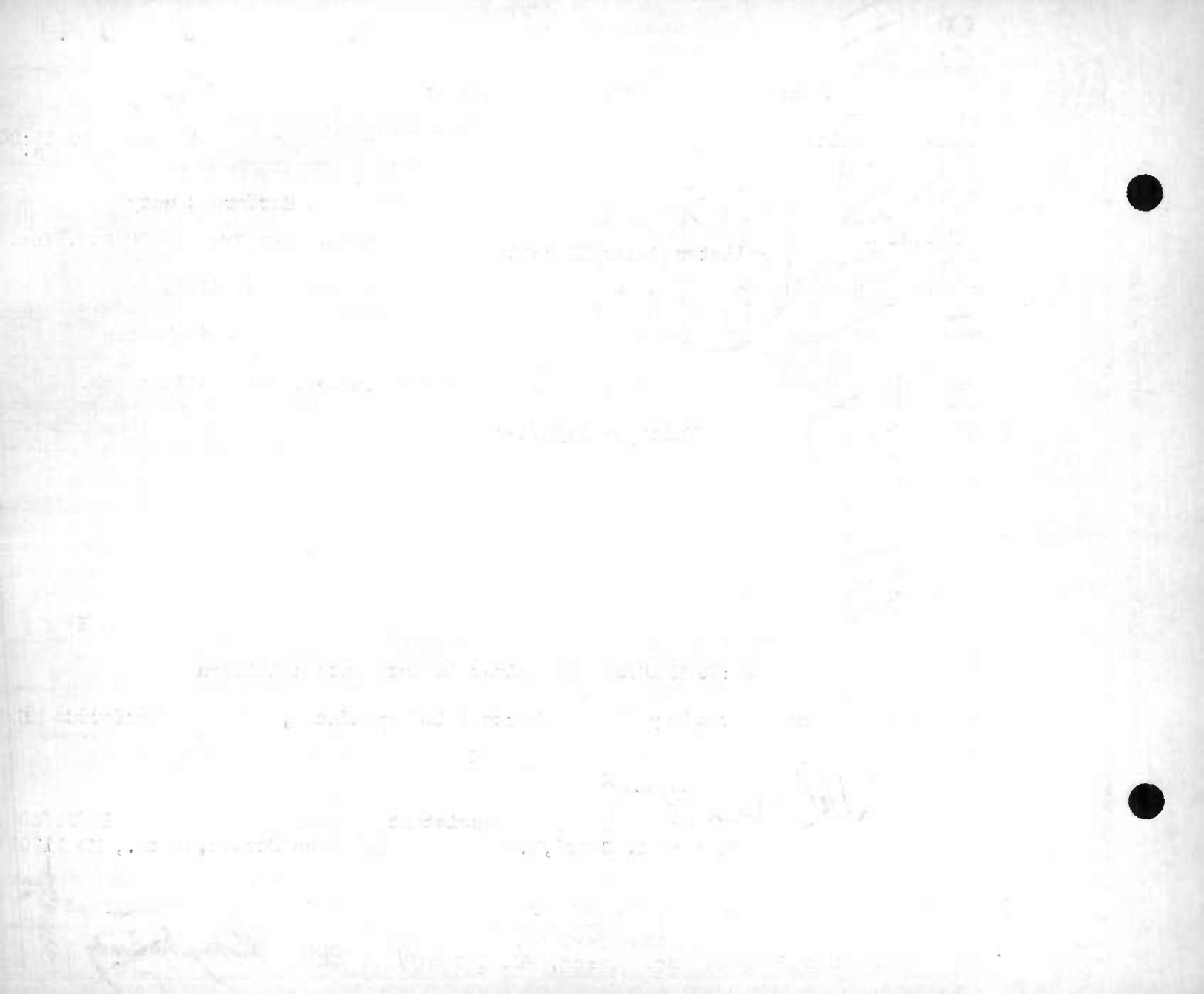
BP

0000 DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26204
REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE Paul		LAST Conner		7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 30 19 80		7b. HOUR M 11:00 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct 12 1928		6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 30 19 80	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7e. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Exec. Vice Pres. HBAM Pub. Inc.				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Hydes		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Church Lane, 21082			
14. FATHER'S NAME FIRST MIDDLE LAST John Rickard Conner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Weinekotter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Korean		17. INFORMANT ADDRESS Andrew T. Conner, 5019 Bellona Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 PM 10/30 19 80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE North of Old Joppa Rd Rt #1, Harford Co MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Hormez R. Guard, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10/31/80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-3-80		23c. NAME OF CEMETERY OR CREMATORY St. John's Long Green				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204						25a. DATE REC'D. BY REGISTRAR NOV 6 1980		25b. REGISTRAR'S SIGNATURE Rickey McBrady					



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

26205
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Barbara Lynn Cooke						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 29 80		2b. HOUR 9:00	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 3 1933		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 29 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Aberdeen				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garage - at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECOM-APG	
13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Norris Roland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maurine Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-30-0550		17. INFORMANT George Szabo, 2333 Camino Del Rio South,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication 9520 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00xx 10 29 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Attached vacuum hose from exhaust into window			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Garage		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11 Hillman Ct., Aberdeen, Harford, Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10/29/80	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/31/80		23c. NAME OF CEMETERY OR CREMATORY Spesutia Epic. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Perryman Harford Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001						25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE <i>Harry McHenry</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



CONFIDENTIAL

NOV 8 1980

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

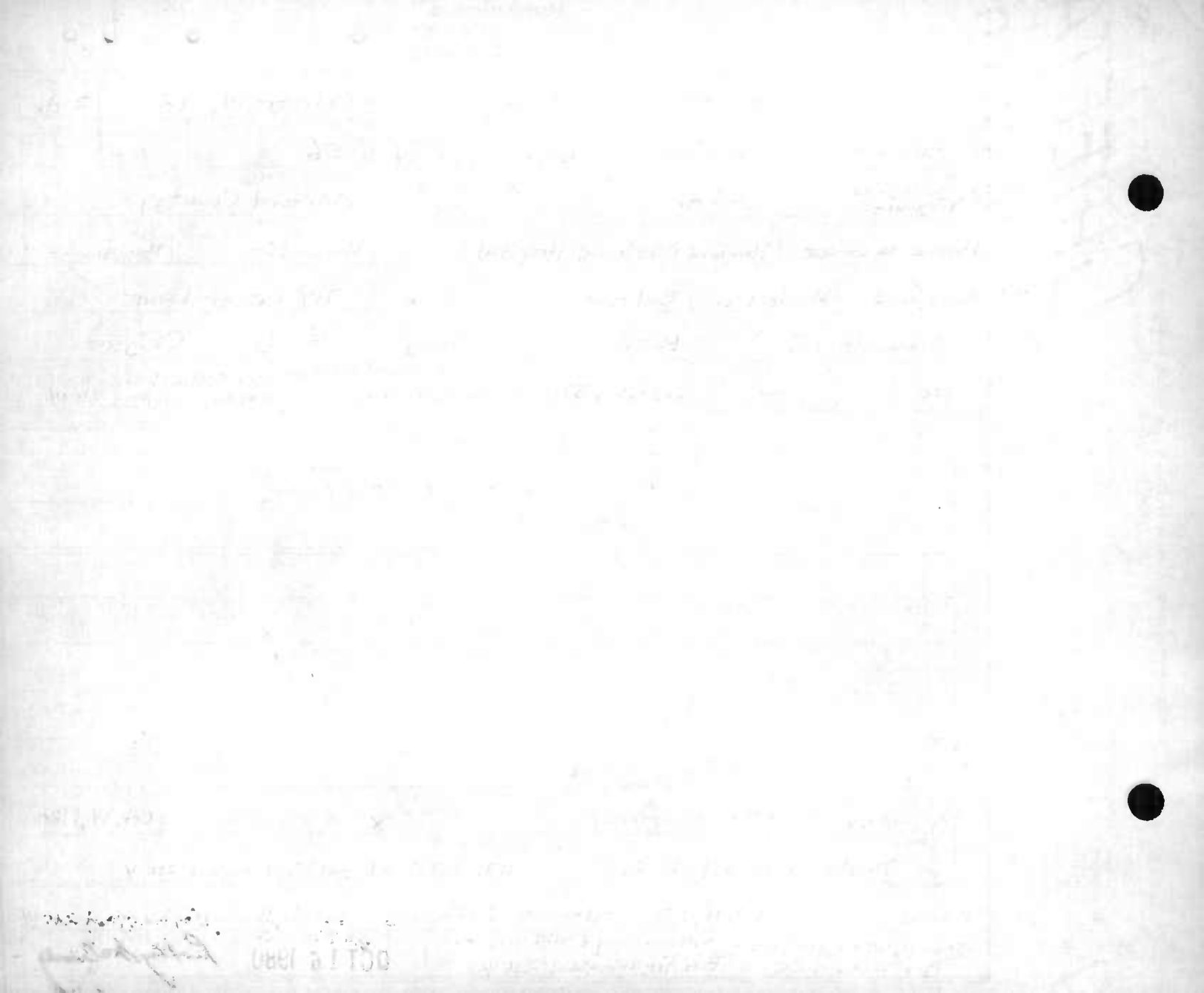
REG. NO.

0 2 6 2 0 6

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
MAMIE FRANCES Cox				October 14, 1980	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	White	MONTH DAY YEAR		56	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Virginia		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
HARVIE DE GRACE		Harford Memorial Hospital		Housewife	
13a STATE		13b COUNTY		13c STREET ADDRESS	
Maryland		Harford Co.		917 CEDAR LANE	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Emmett J. Kegly		Mary Emily Criger			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT (Name and Address)	
NO		213-28-6397		Mr. Louis T. Cox 917 CEDAR LANE Bel Air, Maryland 21014	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AS CAUSE</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>10/1</u> 19 <u>80</u> to <u>10/13</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Dante Monakel, M.D.</u>		22c. DATE SIGNED Oct. 14, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DANTE MONAKEL, M.D.		1131 BEL AIR RD. BEL AIR, MARYLAND 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 16, 1980		Bel Air Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Bel Air, Harford Co., Maryland 21014		OCT 16 1980			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>Superior Funeral</u>		ADDRESS <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Harry A. Bandy</u>	

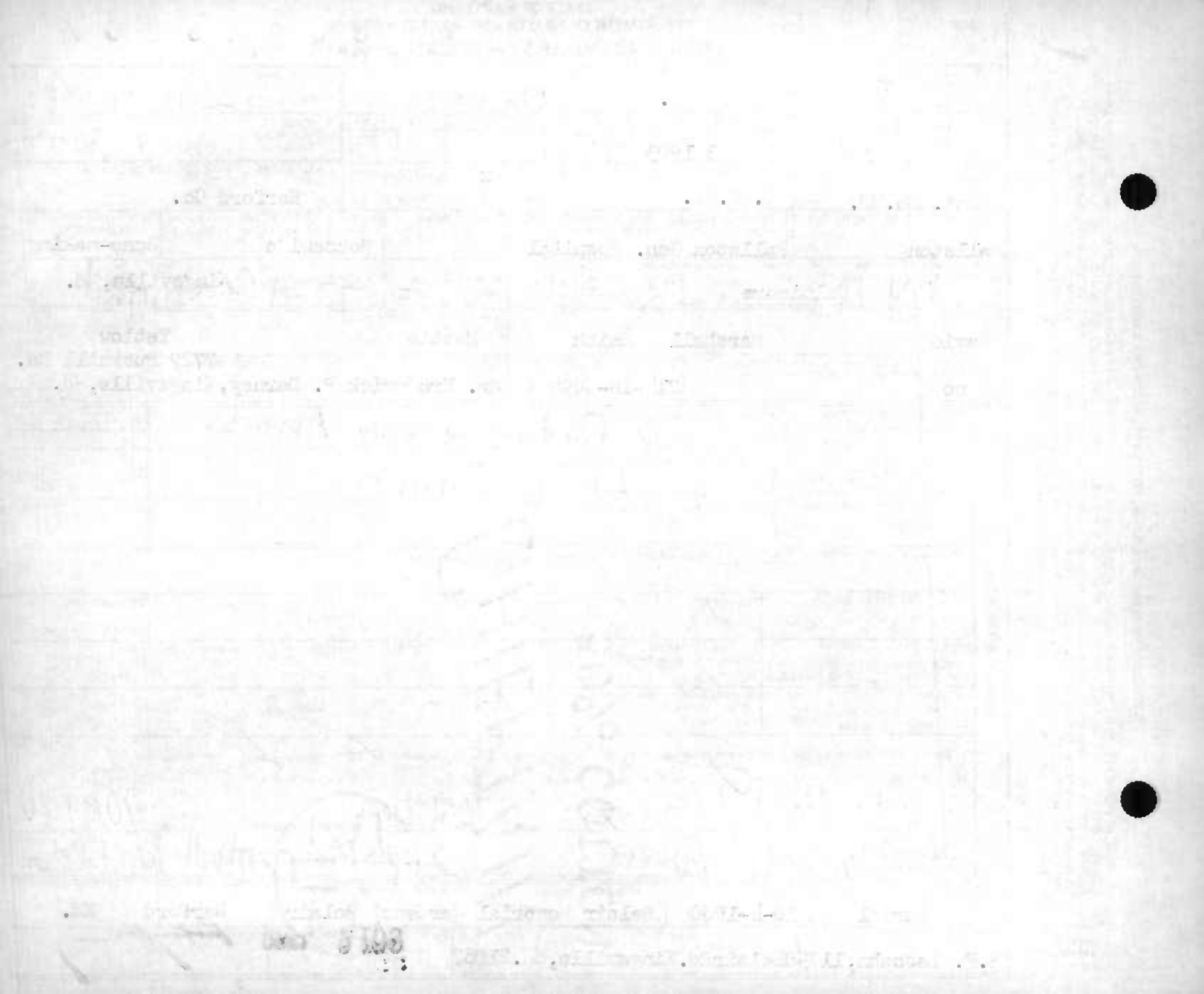
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												26207	
FOR 1- STATE REGISTRAR												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Fennit M. Darney						2a. DATE KNOWN OF DEATH ESTIMATED 10/1/80						2b. HOUR 6:45 PM	
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH 3 DAY 3 YEAR 1903		6. AGE (IN YEARS) LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.		7c. DATE PRONOUNCED DEAD 10/1/80		2d. HOUR 7:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mont. Co. Md.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co.	
10. CITY OR TOWN OF DEATH Fallston				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home-making	
13a. STATE Md				13b. COUNTY Baltimore				13c. CITY OR TOWN Kingsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST David MIDDLE Marshall LAST Smith				15. MOTHER'S MAIDEN NAME FIRST Hattie MIDDLE Tetlow LAST Tetlow				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-16-5894 A	
17. INFORMANT Mr. Frederick P. Darney, Kingsville, Md.				ADDRESS 7729 Buckhill Rd.				21087					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardio-respiratory Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: Lung Cancer (b) Lung Cancer (c) Lung Cancer												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Willard P Amoss				TITLE (SPECIFY) Asst Dep				MEDICAL EXAMINER				DATE SIGNED 10/1/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss				ADDRESS 2404 Pleasantville Rd, Fallston									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-4-1980				23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens				23d. LOCATION CITY OR TOWN Belair COUNTY Harford STATE Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn ADDRESS 11750 Belair Rd. Kingsville, Md. 21087				25a. DATE 10/1/80				25b. REGISTRAR'S SIGNATURE [Signature]				25c. REGISTERED SIGNATURE [Signature]	



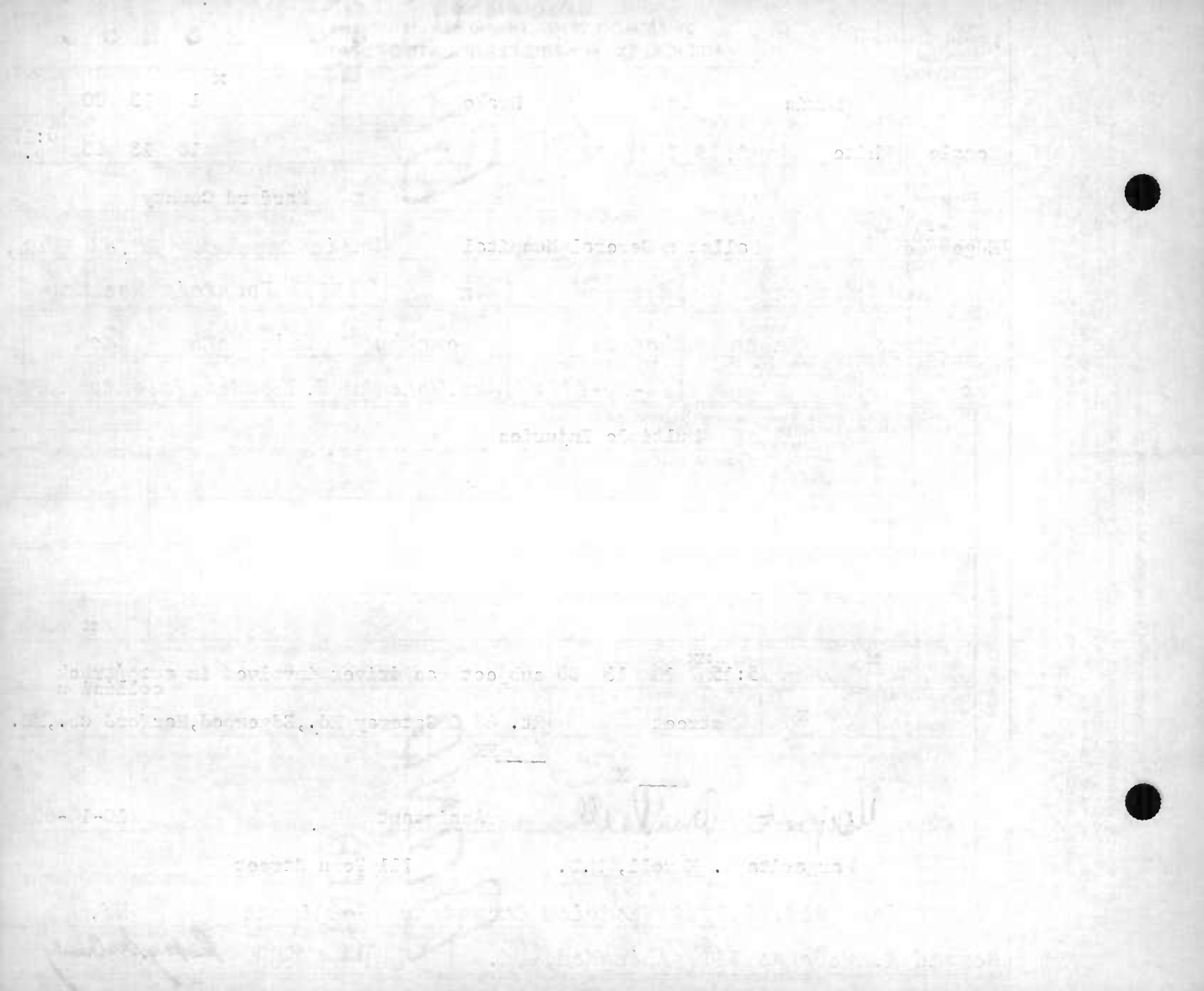
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BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26208	
1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Doris Lee Drake								10 13 1980		6:17 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD	
Female	White	Sept. 30, 1942		38 YRS.						10 13 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Penna.		USA				Harford County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Fallston Edgewood		Fallston General Hospital				Music teacher			Bd. of Educ.		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN											
Maryland Harford Edgewood											
14. FATHER'S NAME (FIRST MIDDLE LAST)						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)					
James Ruben Rhoades						Dorothy Elizabeth Crow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				168-34-6162		Mrs. Dorothy E. Rhoades, Masontown, Pa					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				5:15 P.M. 10 13 1980				subject was driver involved in auto/truck collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
				street				Rt. 40 & Gateway Rd., Edgewood, Harford Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Hospice Director				Assistant				10-14-80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)			
Cremation				Oct. 15, 1980		Westview Crematory		Baltimore Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas III, Abingdon, Md.						OCT 17 1980		H. K. McComas			

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

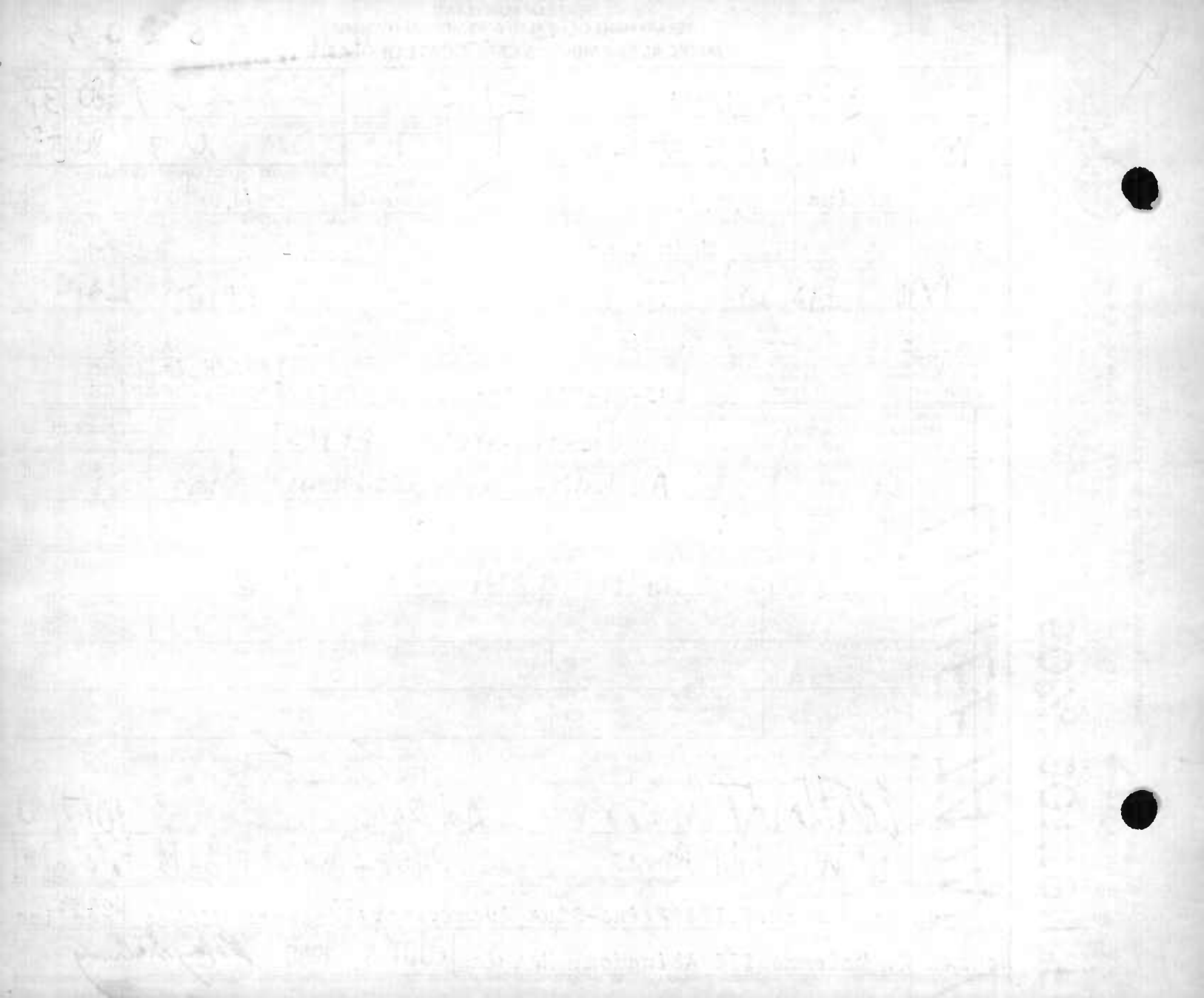
DHMH - 17
(VR AT 15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26209

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST John		MIDDLE (nmn)		LAST Ellis		2a. DATE KNOWN OF DEATH		ESTIMATED 2/10/80		2b. HOUR 3P			
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 11/13/35		6. AGE (IN YEARS) (LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 10/7/80		2d. HOUR 5P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford						MD			
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1606 Heim Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY Clock									
13a. STATE Md		13b. COUNTY Hartford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1606 Heims Lane							
14. FATHER'S NAME FIRST Dardle		MIDDLE --		LAST Ellis		15. MOTHER'S MAIDEN NAME FIRST Nora		MIDDLE --		LAST Brooks					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Mary Anne Ellis		1606 Heim Lane		Joppa, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>303- Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholism with possible aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Probable atherosclerotic heart disease</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Willard R Amos		M.D. Asst Prof		MEDICAL EXAMINER 2404 Pleasantville Rd		DATE SIGNED 10/7/80									
EXAMINER'S NAME (TYPE OR PRINT) Willard R Amos		ADDRESS 2404 Pleasantville Rd													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE Oct. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Reins-Sturdivant, Inc		23d. LOCATION North Wilkesboro		COUNTY Wilkes		North Carolina					
24. FUNERAL DIRECTOR NAME Howard K. McComas III		ADDRESS Abingdon, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 9 1980		25b. REGISTRAR'S SIGNATURE Ricky McRuddy									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26210	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rocky LEE ENGEL										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 11 1980	
3. SEX M 4. RACE Cane 5. DATE OF BIRTH MONTH DAY YEAR 7 2 1963 17 YRS.										2b. HOUR 838 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 11 1980	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.										2d. HOUR 1038 PM	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH Fallston										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital										12b. KIND OF BUSINESS OR INDUSTRY High School	
13a. STATE Md 13b. COUNTY Harford 13c. CITY OR TOWN Forest Hill										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1305 Sharon Acres Road											
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Henry Engel Jr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Elizabeth Thompson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 220-82-8299	
17. INFORMANT Wilhelm H. Engel Jr.										ADDRESS same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8151 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Severe Head & Neck Trauma with Laceration of Right Carotid Artery (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 830 P.M. 10 11 1980										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 830 P.M. 10 11 1980	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Front seat passenger thrown from auto after collision with pole										21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road (Vehicle)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Route 543 north of 100th Ave Rd. Harford Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Willard P. Amoss M.D.										DATE SIGNED 10/12/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss										ADDRESS 2404 Pleasantville Rd, Fallston MD 21057	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 10/15/1980	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.										23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME M. G. Kurtz III										25a. DATE REC'D. BY REGISTRAR OCT 15 1980	
ADDRESS Jarrettsville, Md.										25b. REGISTRAR'S SIGNATURE R. J. Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alfred Laurence Feeney</i>			<i>October 13 1980</i>			<i>4⁴⁵ A M</i>		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. UNDER 1 YEAR MONTHS DAYS		
<i>Male</i>	<i>White</i>	<i>March 7 1908</i>	<i>72</i>					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH					
<i>PA</i>	<i>U.S.A</i>		<i>Hartford</i> MD.					
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY		
<i>Hartford Grace</i>	<i>Hartford Mem. Hosp.</i>		<i>Military</i>			<i>Retired</i>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	17. STATE	18. COUNTY	19. CITY OR TOWN	20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21. STREET ADDRESS			
<i>Md</i>	<i>Md</i>	<i>Hartford</i>	<i>Abbeeden</i>		<i>619 W Bel Air Ave</i>			
22. FATHER'S NAME FIRST MIDDLE LAST	23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		24. INFORMANT ADDRESS					
<i>Patrick Feeney</i>	<i>Elizabeth Stables</i>		<i>Grace R. Feeney - 619 W. Bel Air Ave</i>					
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	26. SOCIAL SECURITY NO	27. ADDRESS						
<i>Yes</i>	<i>213-36-8695</i>	<i>Abbeeden Maryland 21001</i>						
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):								29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1579 Abdominal Corrosion</i>								<i>6 months</i>
DUE TO, OR AS A CONSEQUENCE OF (b):								
<i>Corrosion of Pancreas</i>								<i>6 months</i>
DUE TO, OR AS A CONSEQUENCE OF (c):								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
30. DATE OF OPERATION			31. CONDITION FOR WHICH OPERATION WAS PERFORMED			32. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
34. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			35. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			36. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
37. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			38. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			39. LOCATION STREET CITY OR TOWN COUNTY STATE		
40. I certify that (1) (this hospital) attended the deceased from <i>10-10-80</i> to <i>10-13-80</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (did not) view the body after death.								
41. SIGNATURE			42. DEGREE			43. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		44. DATE SIGNED
<i>Peter P. Rodman, M.D.</i>			<i>8 Law St.</i>			<i>Abbeeden, Md - 21001</i>		<i>10-14-80</i>
45. PHYSICIAN'S NAME (TYPE OR PRINT)			46. ADDRESS			47. DATE REC'D. BY REGISTRAR		
<i>Peter P. Rodman, M.D.</i>			<i>8 Law St.</i>			<i>OCT 27 1980</i>		
48. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			49. DATE			50. NAME OF CEMETERY OR CREMATORY		
<i>Funeral</i>			<i>10/14/1980</i>			<i>Bel Air Memorial Gardens</i>		
51. FUNERAL DIRECTOR NAME			52. ADDRESS			53. DATE REC'D. BY REGISTRAR		
<i>Turning Funeral Home - abbeeden - Md.</i>			<i>Abbeeden - Md.</i>			<i>OCT 27 1980</i>		
54. REGISTRAR'S SIGNATURE			55. REGISTRAR'S SIGNATURE					
<i>Hartford</i>			<i>Hartford</i>					

BP

OCT 17 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Medora Crusier Fogle			2a. DATE OF DEATH MONTH DAY YEAR Oct. 14 1980			2b. HOUR 8:16 P^M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR JUNE 25, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 506 Camilla St.	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM BALDWIN CRUSER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN MAY CLARKE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 057-09-2354		17 INFORMANT ADDRESS BERNARD L. FOGLE, 205 W. 21st PLACE, YUMA, ARIZONA.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL DEATH 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS (c) ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 - 13 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-13 19 80 , to 10-16 19 80 , that (I) (we) last saw the deceased alive on 10-16 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante N. Monakile				DEGREE		22c. DATE SIGNED 10-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKILE				22e. ADDRESS 622 S. Union Ave Havre de Grace, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 20, 1980		23c. NAME OF CEMETERY OR CREMATORY HENNINGTON RURAL		23d. LOCATION CITY OR TOWN COUNTY STATE SOFFOX CO. MD	
24 FUNERAL DIRECTOR R. Madison Mitchell				25a. DATE REC'D. BY REGISTRAR OCT 20 1980		25b. REGISTRAR'S SIGNATURE Robert A. Brady	

R. William Mitchell, Harvard Grace No. OCT 20 1980

BURIAL OCT 20 1980 Washington Monument - 2000000000

Donor R. William Mitchell

Donor R. William Mitchell

11-11-80 10-13-80 10-10-80

INTERVIEWERS

GENERAL THOMAS

CERIAL DEATH

Oct 20 1980

William Edwin Groser

MAY

CLARKE

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

DHMH-17
(VR A15 ME (5))
15M7/77

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. **PENDING** IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM, 2. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 6 2 1 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THELMA MARTIN GRIMES		LAST GRIMES		2a. DATE KNOWN OF DEATH ESTI- MATED 10 5 1980		2b. HOUR DAY YEAR 8:00 PM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11 10 1908	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7c. DATE PRONOUNCED DEAD 10 6 1980	7d. HOUR DAY YEAR 10:00 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAVRE DE LAPE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 421 ST. JOHN ST.				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Waitress	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE LAPE		13d. STREET ADDRESS 421 ST. JOHN ST.	
14. FATHER'S NAME FIRST MIDDLE LAST George Henry Martin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie NMN CREASEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 235-26-6932		17. INFORMANT ROY SHIELDS ADDRESS 218 W. 8th St. HAVRE DE LAPE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Heart disease 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) ASCVD. (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Luis E. RENTEL		TITLE (SPECIFY) M.D. DEPUTY		MEDICAL EXAMINER		DATE SIGNED 10/6/80	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. RENTEL, MD		ADDRESS 464 ALLIANCE ST. HAVRE DE LAPE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 8, 1980		23c. NAME OF CEMETERY OR CREMATORY DANVILLE MEMORIAL Gd.		23d. LOCATION CITY OR TOWN COUNTY STATE DANVILLE PENNSYLVANIA	
24. FUNERAL DIRECTOR NAME PENNINGTON & SON		ADDRESS HAVRE DE LAPE MD		25a. DATE REC'D. BY REGISTRAR OCT 9 1980		25b. REGISTRAR'S SIGNATURE Robert M. B...	

NOV 1910



Handwritten notes or signatures on the left side of the page.

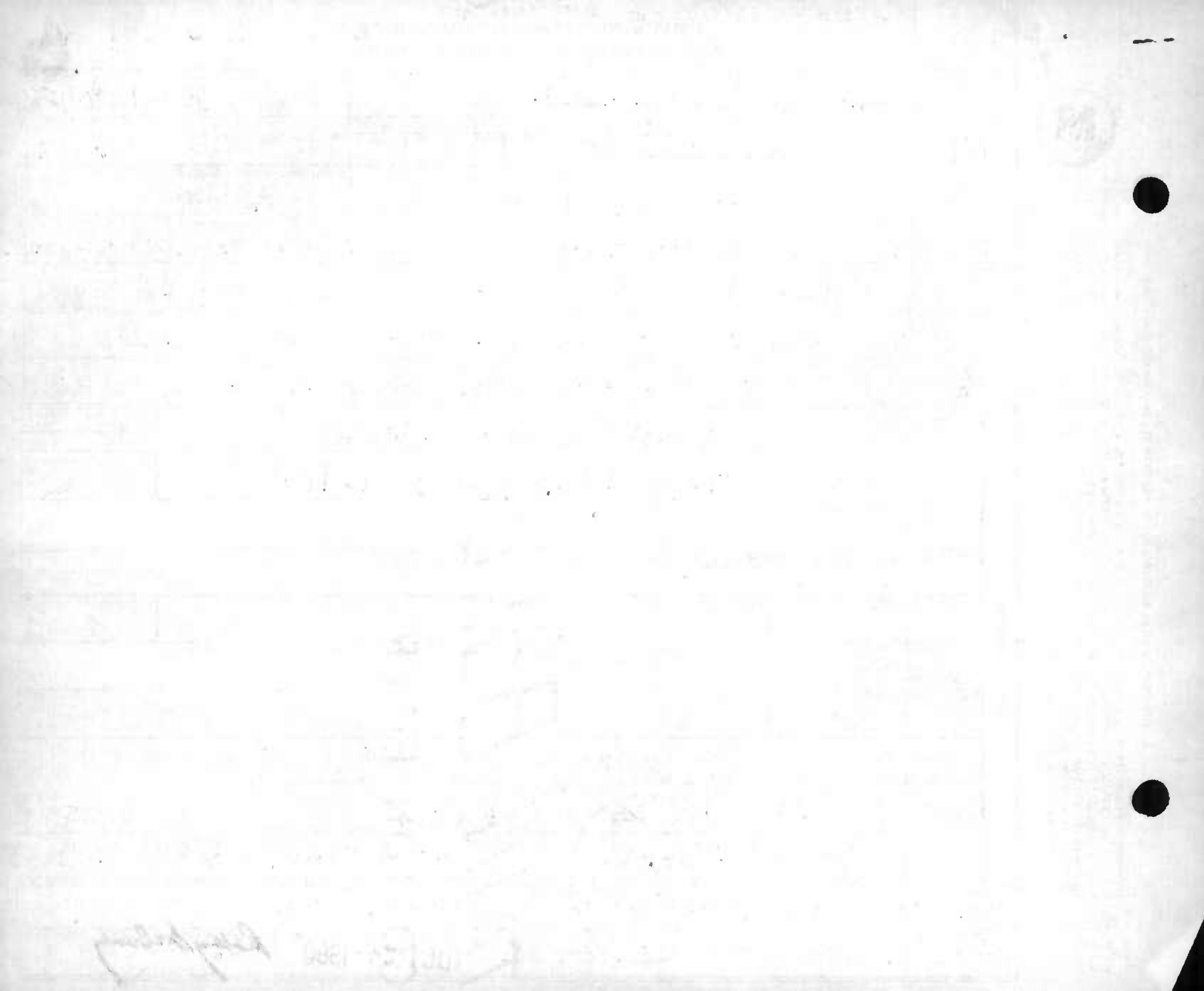
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR THE MEDICAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

MEDICAL CERTIFICATION

1- STATE REGISTRAR				26214			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM - MIDDLE CARROLL LAST GUNTHER				2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 25 Oct 19 80			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 10 DAY 25 YEAR 1980	6. AGE IN YEARS (LAST BIRTHDAY) 66 YRS.	7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	7. IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD 25 Oct 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 225 W. Hall Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director, Proc. Div, US-govt.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Hartford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 225 West Hall Street		14. FATHER'S NAME FIRST William MIDDLE Frederick LAST Gunther		15. MOTHER'S MAIDEN NAME FIRST Kathryn MIDDLE -- LAST Carroll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR NAVY) WWII 220-207758		17. INFORMANT ADDRESS Mrs. Margaret A. Gunther, Bel Air, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to abdomen DUE TO, OR AS A CONSEQUENCE OF (b) Terminal Cancer of Colon to Liver DUE TO, OR AS A CONSEQUENCE OF (c) 1539 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Willard P. Amoss		TITLE (SPECIFY) Asst Dir		MEDICAL EXAMINER		DATE SIGNED 10/25/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss		ADDRESS 2404 Pleasantville Rd, Fallston Md 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR OCT 27 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR					REG. NO. 8 0 2 6 2 1 5				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Elma Hargis					2a. DATE OF DEATH MONTH DAY YEAR Oct 4 1980			2b. HOUR 7:30 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 6 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY SAME	
13a. STATE MD.		13b. COUNTY Harford		13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 415 S. MARKET STREET CITIZENS NURSING HOME	
14. FATHER'S NAME FIRST MIDDLE LAST ELMER ELLSWORTH ANDREW					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TACY (N.M.N.) JOHNSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216 825 429		17. INFORMANT J. PERRY HARGIS		ADDRESS HARRE DE GRACE 4154 U. WAY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Supine wall myocardial Infarct 30g (c) airflow into heart during									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1dg
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (1) Cerebro-vascular thrombosis, Ductus Arteriosus kept									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 9-24 19 80 , to 10-4 19 80 , that (I) (we) last saw the deceased alive on 10-4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Irvin L. Wachsmann					DEGREE MD		22c. DATE SIGNED 10/4/80		22b. ADDRESS 407 S. Union Ave. Harre de Grace Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/8/1980		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HARRE DE GRACE HARFORD MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Pennington + Son, Harre de Grace, Md.									

BP

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1981

CITIZENS

0018 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 6 2 1 6			
1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Walter Lester Head Jr.				Oct. 8 1980				5A AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
male		white		JUNE 25, 1951		29 YRS.		MONTHS DAYS		HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				HARFORD MD.					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY					
HAURE de GRACE		HARFORD Memorial Hosp.		BAKERS HELPER		BAKERY					
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				17. INSIDE CITY LIMITS?				18. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3613 Dublin Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
WALTER L. HEAD				HILDA BOWMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS			
No				220-54-9277				HILDA B. HEAD, DARLINGTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Basal Ganglia Degeneration (Atrophy)</u>											
3319 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22a. SIGNATURE				DEGREE				22c. DATE SIGNED			
LETICIA S. GALVEZ				M.D.				10/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
LETICIA S. GALVEZ, M.D.				625 S. UNION AVE. HAURE DE GRACE MD. 21075							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				OCT. 11, 1980		DARLINGTON		DARLINGTON, HARFORD, MD.			
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				OCT 10 1980							
JOHN H. HARKINS, DELTA, PA.											

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

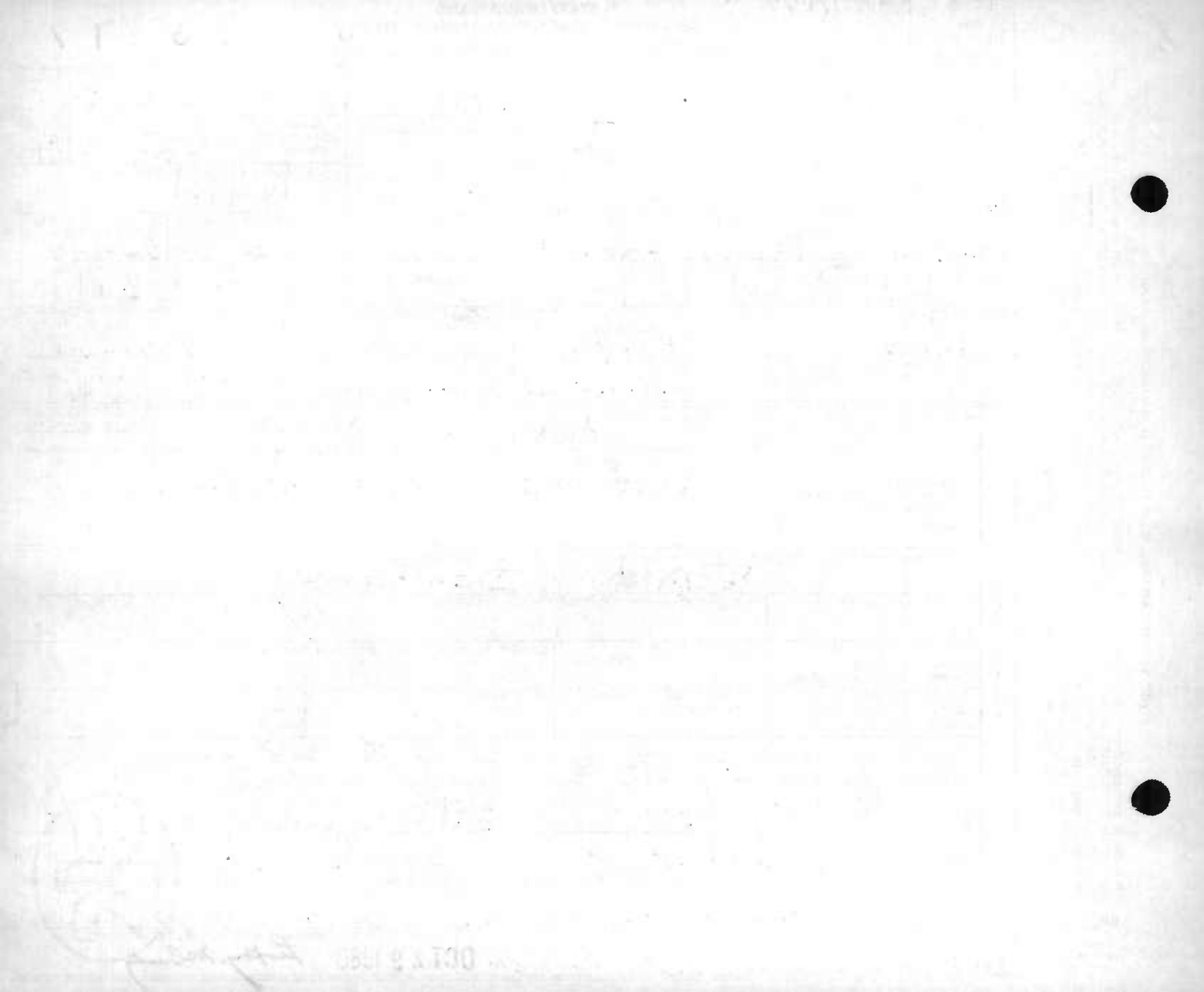
REG. NO. 26217

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Nellie Mae Henry		2a. DATE KNOWN OF DEATH 2 10 25 19 80		2b. HOUR 6 30 A	
3. SEX F	4. RACE Cauc	5. DATE OF BIRTH 12 24 04 79	6. AGE IN YEARS 79	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 10 25 19 80	2d. HOUR 10 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Darlington, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH OBERLANDER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-16-7600	
16c. INFORMANT ADDRESS ERNEST D. HENRY, JR. 2604 GREGORY PLACE FOREST HILL, MD.		17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Arteriosclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Willard P. Amoss		TITLE (SPECIFY) Med Ex		MEDICAL EXAMINER		DATE SIGNED 10/25/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss		ADDRESS 2404 Hoesentville Rd Fallston Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE DARLINGTON, HARFORD, MARYLAND	
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS		ADDRESS 600 MAIN ST. DELTA, PA. 17314		25a. DATE REC'D. BY REGISTRAR OCT 29 1980		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26218	
1. DECEASED NAME (TYPE OR PRINT) Joseph (NMN) Hybner										2a. DATE KNOWN OF DEATH ESTIMATED 10-17-80					7b. HOUR 230						
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 1 04		6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 17 19 80					7d. HOUR 230				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CZECHOSLOVAKIA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD									
10. CITY OR TOWN OF DEATH Aberdeen				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial						12a. USUAL OCCUPATION (TYPE OF WORK) SHOEMAKER				12b. KIND OF BUSINESS OR INDUSTRY SHOE MFR.							
13a. STATE Md										13b. COUNTY HARFORD		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 412 Rogers ST.					
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 215-18-3677				17. INFORMANT ADDRESS Hospital Chart													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. ASCVD (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 10-17-80									
EXAMINER'S NAME (TYPE OR PRINT) Luis E. RENJEL				ADDRESS 464 Alliance St Havre de Grace Md 21077																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 10/18/1980		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley, Inc., Balto., Md. 21222										25a. DATE REC'D. BY REGISTRAR OCT 23 1980		25b. REGISTRAR'S SIGNATURE Walter Brooks Bradley									

28-14-3254
Holtzman Clark

Country A

1945-1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 6 2 1 9	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>INA M. Jones</u> <u>INA MARY JONES</u>				2a. DATE OF DEATH MONTH <u>10</u> DAY <u>20</u> YEAR <u>80</u> 9:25 P.M.	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>08</u> DAY <u>18</u> YEAR <u>05</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS. IF UNDER 1 YEAR: MONTHS <u> </u> DAYS <u> </u> IF UNDER 24 HRS: HOURS <u> </u> MIN. <u> </u>	
10. CITY OR TOWN OF DEATH <u>Fallston</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fallston General Hospital</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Harford Co.</u> 13c. CITY OR TOWN <u>Fallston</u>				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>housewife</u>	
14. FATHER'S NAME FIRST <u>Wilburn</u> MIDDLE <u> </u> LAST <u>Rhodes</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Ruth</u> MIDDLE <u> </u> LAST <u>Reedy</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <u>2129 Buell Drive</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>218-12-4612</u>		17. INFORMANT (See 1838-4439 ADDRESS) <u>Mrs. J. Gantley Jones</u> <u>914 Prospect Mill Road</u> <u>Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>410-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiogenic shock</u> (c) <u>MI</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>2 d</u> <u>22 d</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>					
19a. DATE OF OPERATION <u>29</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u> </u> P.M. <u> </u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>28 Sept</u> 19 <u>80</u> to <u>20 Oct</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>20 Oct</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <u>T. B. Harrison</u>				23b. DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 23c. DATE SIGNED <u>20 Oct 80</u>	
24. PHYSICIAN'S NAME (TYPE OR PRINT) <u>T. B. Harrison</u>				25a. ADDRESS <u>FGH, 200 Mt. Vernon Ave, Fallston</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Oct. 23, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baptist View Church Cemetery</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25b. DATE REC'D. BY REGISTRAR <u>OCT 24 1980</u>		25c. REGISTRAR'S SIGNATURE <u>Barbara A. ...</u>	
25. ADDRESS <u>W. Broadway Williams St</u> <u>Bel Air, Maryland 21014</u>		26. LOCATION CITY OR TOWN COUNTY STATE <u>Forest Hill, Harford Co., Maryland 21050</u>		27. DATE SIGNED <u>20 Oct 80</u>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGES 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26220

1. DECEASED NAME (TYPE OR PRINT)		FIRST Amos		MIDDLE Filmore		LAST Kindle		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 10		DAY 5		YEAR 1980		2b. HOUR PM 11:37	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 1 1931		6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 5 1980		2d. HOUR PM 11:37			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.											
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder				12b. KIND OF BUSINESS OR INDUSTRY Cement Co.					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 620 N. Stokes Street									
14. FATHER'S NAME FIRST MIDDLE LAST Namon (N.M.N.) Kindle						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORRELA (N.M.N.) PLUME											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK.				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unk.		17. INFORMANT ADDRESS Beulah Wyatt, 620 N. Stokes Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Hormez R. Guard, MD.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 10/6/80									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street, Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/9/1980		23c. NAME OF CEMETERY OR CREMATORY RINGGOLD CEMETERY				23d. LOCATION CITY OR TOWN COUNTY WASHINGTON, Md.							
24. FUNERAL DIRECTOR NAME Pennington, Havre de Grace Md.																	
DATE REC'D. BY REGISTRAR OCT 9 1980																	





DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
15M 7/76

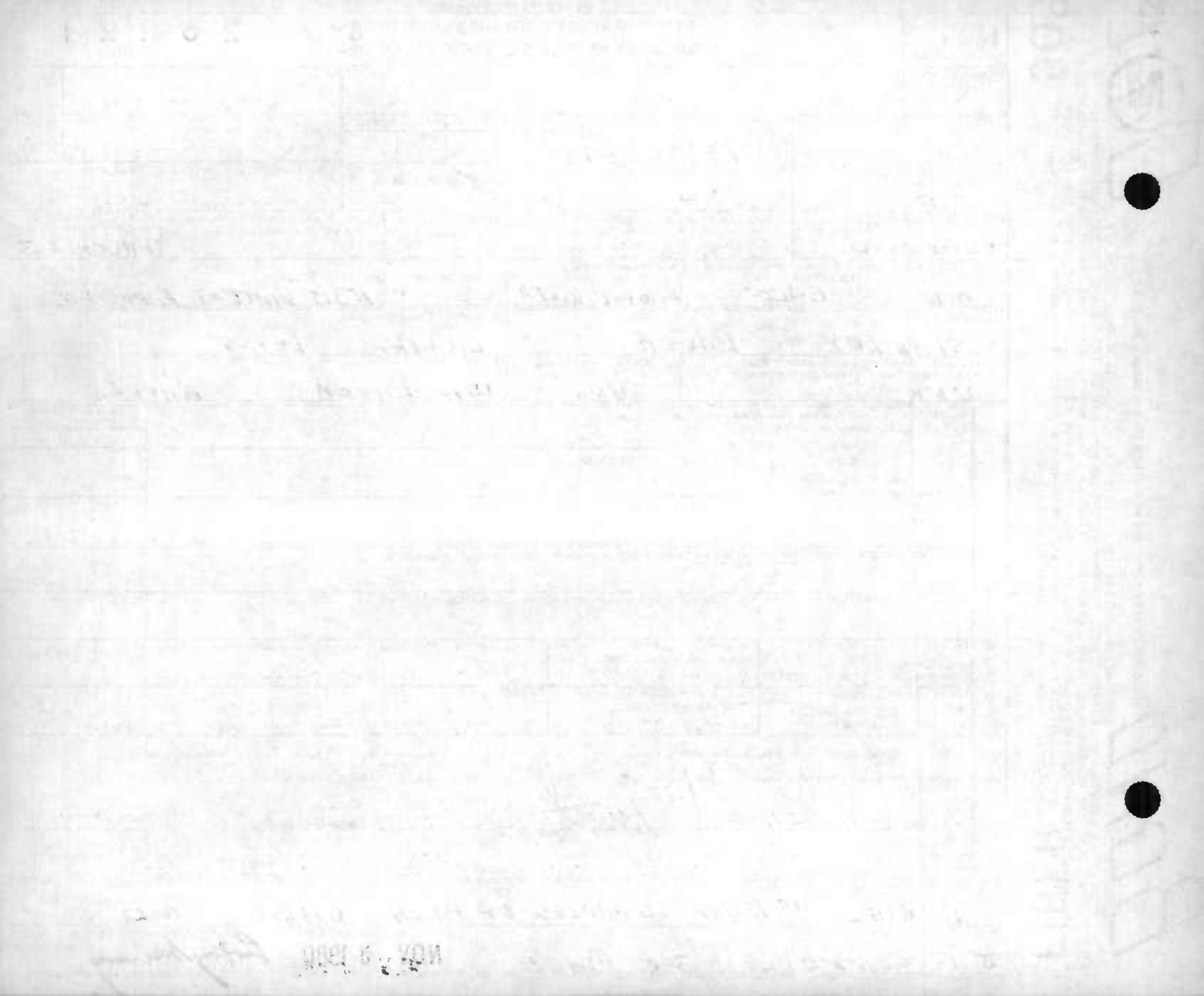
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26221

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Roy Calvin Lauer			2a. DATE OF DEATH KNOWN OF ESTI- MATED 10 27 19 80			2b. HOUR M				
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11/23/50	6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD 10 28 19 80			7d. HOUR 3 A M	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.				
10. CITY OR TOWN OF DEATH EDGEWOOD		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 ft. off Winters Run Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCKING		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN MIDDLE RIVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10315 VINCENT FARM LN.		
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY LAUER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN LEISS			16. SOCIAL SECURITY NO. UNK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK			16b. SOCIAL SECURITY NO. UNK			17. INFORMANT IDA LAUER ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u> 8682 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? xxx 10 27 19 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) inhaled exhaust fumes from auto				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, REST, FACTORY, FARM, ETC.) auto- off road			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 300 ft. off Winters Run Road Harford, MD.				
22a. I certify that I took charge of the remains described above, held on autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy Chief						DATE SIGNED 10/28/80	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/31/80		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MACE			25a. DATE REC'D. BY REGISTRAR NOV 3 1980			25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 2 6 2 2 2							
1 DECEASED NAME (TYPE OR PRINT) Elizabeth Limmer					2a DATE OF DEATH MONTH DAY YEAR 10-02-80		2b HOUR M 10		
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 08 12 89		6 AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford			
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Ctr., Inc.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md.		13b COUNTY Talbott		13c CITY OR TOWN Easton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RD 4, Bx 200, Easton, Md. 21601	
14 FATHER'S NAME FIRST MIDDLE LAST John Barnickie					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hertel				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATERS) WA528460		17 INFORMANT ADDRESS Margaret Scharoun, RD4, Bx200, Easton, Md. 21601					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) new DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months week									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca Breast									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 02/19/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.									
22b. SIGNATURE J. de la Cruz		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct 3, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. de la Cruz		22e. ADDRESS Belair, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 6, 1980		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. 7110 Belair Rd.		Baltimore, Md. 21206		25a. DATE REC'D. BY REGISTRAR OCT 9 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										7. 0 2 6 2 2 3	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH WILLIAM MAGEE						2a. DATE OF DEATH MONTH 10 DAY 28 YEAR 80		2b. HOUR 2:15 AM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 12 YEAR 90		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 208 Hillendale Road			
14. FATHER'S NAME FIRST GEORGE MIDDLE HEMAN LAST MAGEE				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Louise LAST Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 019-09-3805		17. INFORMANT (Last, first, middle) Mrs. Virginia F. Brackins		ADDRESS 20 East Janeltville Road Forest Hill, Maryland 21050					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 2859 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) myocardial infarction (c) Anaemia DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Renal Failure, Benign Prostatic hypertrophy, Haemophysis											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/26/80 to 10/28/80 , that (I) (we) last saw the deceased alive on 10/28/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Antonio Martin M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/28/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO MARTIN				22e. ADDRESS FALLSTON GENERAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 31, 1980		23c. NAME OF CEMETERY OR CREMATORY VINE HILLS Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Plymouth, Plymouth Co., MASS. 02360					
24. FUNERAL DIRECTOR Joseph W. Coster W. Broadway & Williams Street Superiorville Trsco Bel Air, Maryland 21014				25a. DATE REC'D BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE Henry McElroy					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 6 2 2 4
 REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) DANIEL MAUK, SR.		2a. DATE KNOWN OF DEATH 10/29/80		2b. HOUR 4:45 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 6, 1909	6. AGE (IN YEARS) 71	7. IF UNDER 1 YR. MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD 10/29/80	2d. HOUR 4:45 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harris County	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (GIVE COMPLETE ADDRESS) Fallston Gen Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipper		12b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
13a. STATE Maryland		13b. CITY Fallston		13c. STREET ADDRESS 2401 Plainfield Drive			
14. FATHER'S NAME FIRST Albert MIDDLE - LAST Mauk		15. MOTHER'S MAIDEN NAME FIRST Caroline MIDDLE - LAST Coughneur					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 213-07-4551		17. INFORMANT ADDRESS May Mauk, wife, same address, 21047			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest (b) Possible Aspiration (c) Possible Acute Myocardial Infarction							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hydrocephalus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Willard R. Amoss		TITLE (SPECIFY) Asst. Dir.		MEDICAL EXAMINER		DATE SIGNED 10/29/80	
EXAMINER'S NAME (TYPE OR PRINT) Willard R. Amoss		ADDRESS 2404 Pleasantville Rd, Fallston Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/3/80		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Chimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane Balto., Md. 21213		25a. DATE REC'D. BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0026225

1. DECEASED NAME (TYPE OR PRINT) Doris Jeanette McClellan			2a. DATE OF DEATH MONTH DAY YEAR Oct 23 1980			2b. HOUR 9 ¹⁵ P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 5 28 1937		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Laurel de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14 Liberty St.	
14. FATHER'S NAME FIRST MIDDLE LAST Kermit Hartsock				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Bowling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-34-6874		17. INFORMANT ADDRESS Fred McClellan, 14 Liberty St., Aberdeen, Md. 21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatous-includes pulm. metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rectal adenocarcinoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 16</u> , 19 <u>80</u> , to <u>Oct. 23</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Oct. 23</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Charles W. Foley Jr. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. FOLEY JR. M.D.						22e. ADDRESS LAUREL DE GRACE, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/26/1980		23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland		
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001						25a. DATE REC'D. BY REGISTRAR OCT 28 1980		25b. REGISTRAR'S SIGNATURE R. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked in item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

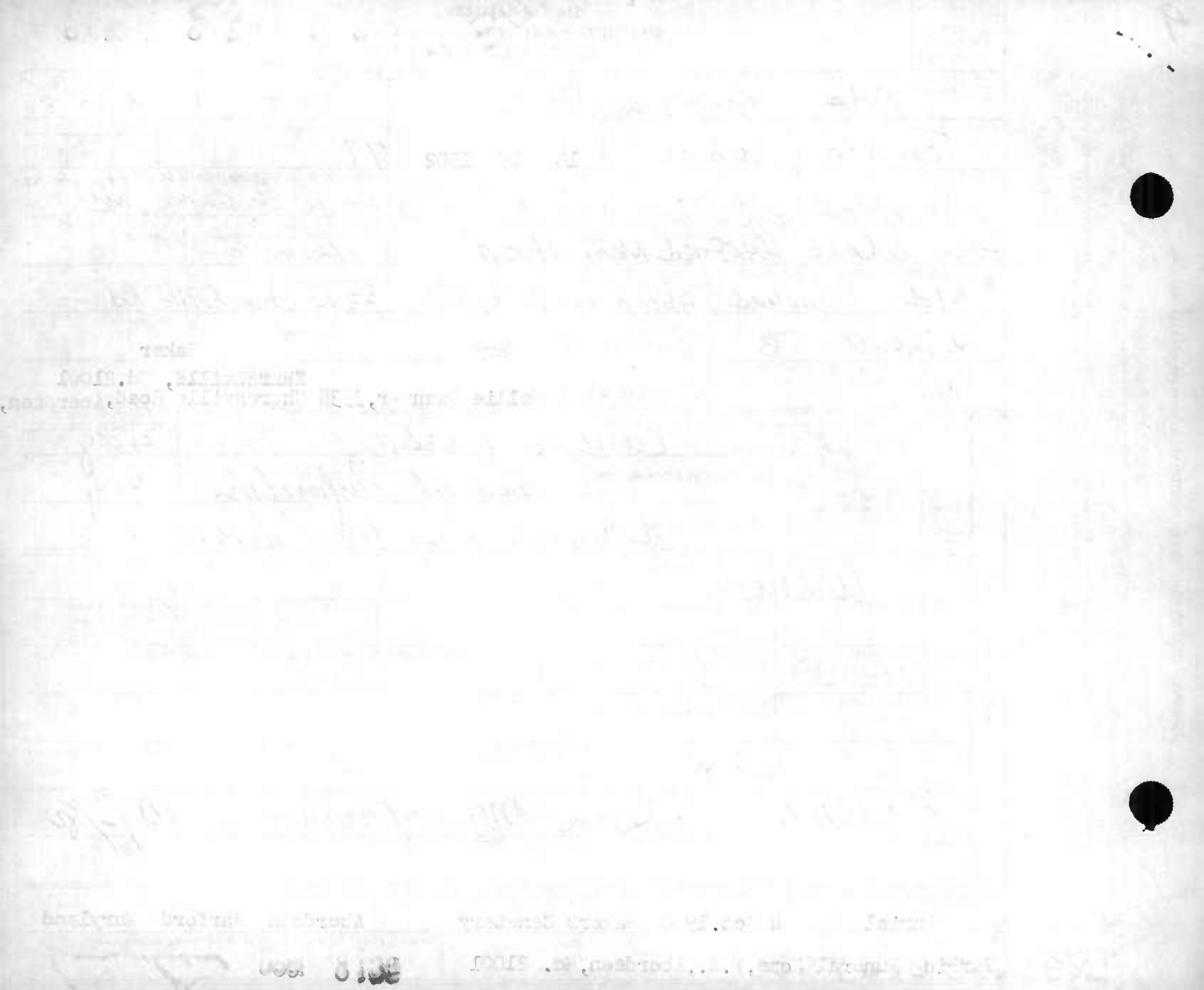
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ada Greenland Melius</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct. 1, 1980</i>			2b. HOUR MIN <i>12⁰⁰ P M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 29 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD. <i>House of Grace, Md</i> MD.	
10. CITY OR TOWN OF DEATH <i>House of Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i>			13c. COUNTY <i>Harford</i>		13d. CITY OR TOWN <i>Aberdeen</i>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <i>3340 Churchville Rd -</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Winfield B Greenland</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Baker</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-05-8040</i>			17. INFORMANT ADDRESS <i>GREENVILLE, Md. 21001</i> <i>Nellie Swanner, 3338 Churchville Road, Aberdeen,</i>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>410 -</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis (heart disease)</i> <i>4 days</i> <i>4 days</i> <i>4 days</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Uremia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/25/80</i> 19 to <i>Oct 1</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>10/1/80</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William H. McGinnis</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/2/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4 Oct. 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Aberdeen Harford Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 8 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 2 6 2 2 7			
1. DECEASED NAME (TYPE OR PRINT) Elmer Ellsworth Pearson				2a. DATE OF DEATH MONTH DAY YEAR Oct 23 1980			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 26 1899		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Therapist/Retired U.S. Gov't		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 		13b. COUNTY Harford 		13c. CITY OR TOWN Aberdeen 		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Pearson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianne Silver		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 			
16b. SOCIAL SECURITY NO. WW-1 		17. INFORMANT Elsie M. Pearson 		ADDRESS Maryland 21001 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Ca of stomach DUE TO, OR AS A CONSEQUENCE OF (c) Arterio sclerotic Cardiovascular 		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. ADDRESS	
22b. I certify that (I) (this hospital) attended the deceased from Oct. 8 19 80 , to Oct. 23 19 80 , that (I) (we) lost saw the deceased alive on Oct. 23 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22c. SIGNATURE J. T. Lee 		DEGREE M.D. 		22d. DATE SIGNED 10/23/80 	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. LEE 		22f. ADDRESS Union Med. Clinic, Havre de Grace 		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 		23b. DATE 10/25/80 	
23c. NAME OF CEMETERY OR CREMATORY St. Marks Episcopal 		23d. LOCATION CITY OR TOWN COUNTY STATE Aiken Cecil Maryland 		24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001 		25a. DATE OF REGISTRATION OCT 28 1980 	
25b. REGISTRAR'S SIGNATURE [Signature] 							



[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side. Some words like "THE", "AND", "OF" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 6 2 2 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HELENA		FIRST M.		MIDDLE POZDENA		LAST	
2a. DATE OF DEATH MONTH DAY YEAR 10 15 80		2b. HOUR 10:20 PM		3. SEX FEMALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR 11-1-98		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.		10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NSG. HOME	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Cleaning		13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 707 Burnside Drive, 21014		13f. CITY OR TOWN Bel Air, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST John - Tanner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena - Barth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-30-9574	
17. INFORMANT ADDRESS Harry Pozdena, son, same address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4280 DUE TO, OR AS A CONSEQUENCE OF (b). Pneumonia Congestive heart disease DUE TO, OR AS A CONSEQUENCE OF (c).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1-9-79, 1980, to 10/16/80, that (I) (we) lost saw the deceased alive on 10/16/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE John Yun	
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Yun		22e. ADDRESS		22f. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/80		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR Name M. J. M. Funeral Home, Inc.		25. ADDRESS 9705 Belair Road Balto., Md. 21236		26. REG. BY REGISTRAR 11-21-1980		27. REGISTRAR'S SIGNATURE [Signature]	

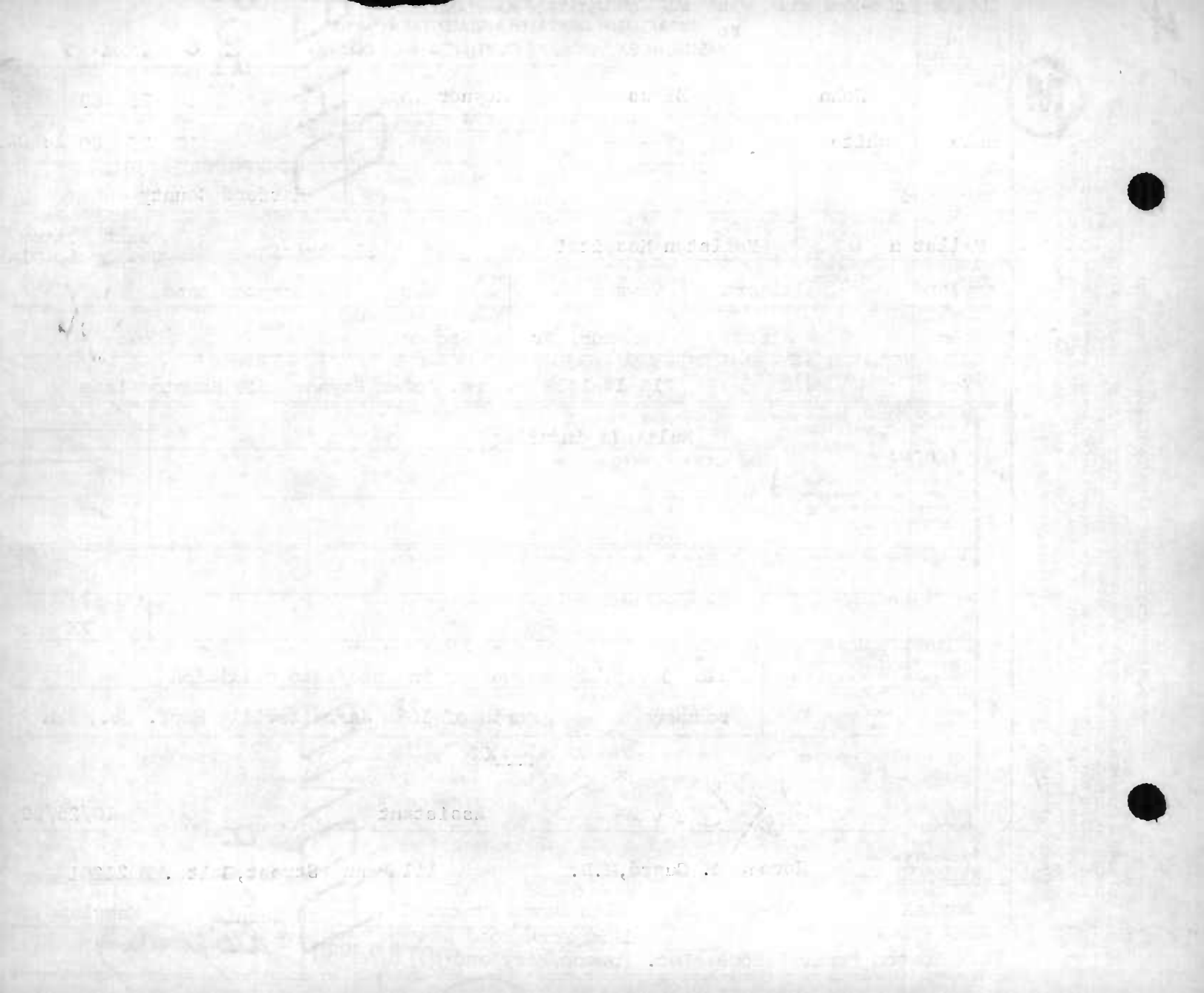


Handwritten signature

0801 1280

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D. NO. 26229	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
John Bloss Raynor, JR.								XX MONTH DAY YEAR 10 25 1980		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	white	Feb. 25, 1923		57 YRS.					10 25 1980		1:40A.M.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Harford County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston Hospital				Electrician		Peach Bottom Catalytic Plant			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		519 Hampton Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John Bloss Raynor, Sr				Rachael Howe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
Yes		WW 2		218-14-1458				Mrs. JoAnn Raynor 519 Hampton Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Multiple injuries											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				12:10 10/25/1980		passenger in auto/auto collision					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
				roadway		North of 165 Jarrettsville Harf. Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Hormez R. Guard, M.D.				Assistant				10/26/80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Hormez R. Guard, M.D.				111 Penn Street, Balto. MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		10-29-1980		Glen Haven Memorial		Glen Burnie		Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
Ruck Towson Funeral Home, Inc.				1050 York Road Towson, Maryland				OCT 27 1980			



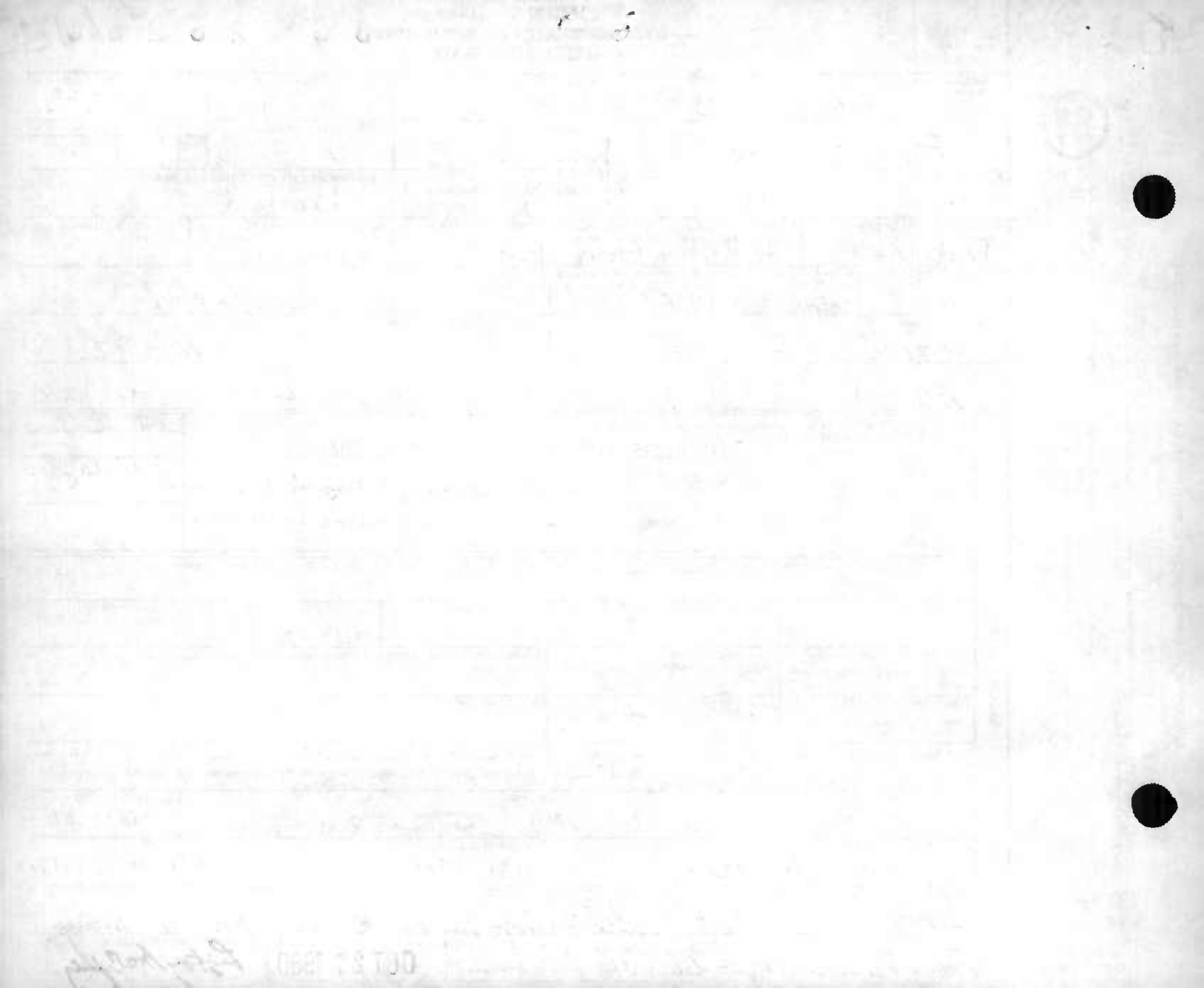
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8 0 2 6 2 3 0			
1. FOR STATE REGISTRAR							
1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE D. LAST Roberts				2a. DATE OF DEATH MONTH 10 DAY 16 YEAR 80		2b. HOUR 3 57 A.M.	
3 SEX FEMALE		4 RACE W		5 DATE OF BIRTH MONTH 04 DAY 12 YEAR 13		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Fallston Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST horozu MIDDLE E. LAST Hickok				15 MOTHER'S MAIDEN NAME FIRST Fozzie MIDDLE Rinzle LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO 157-07-016		17 INFORMANT ADDRESS CHESTER ROBERTS 422 ROBERTS WAY, ABERDEEN			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram -ve, Pseudomonas septic shock. 2041 DUE TO, OR AS A CONSEQUENCE OF - Neutropenia, L. Lingular Pneumonia. (b) DUE TO, OR AS A CONSEQUENCE OF - Chronic Lymphocytic Leukemia. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-12-1980, to 10-16-1980, that (I) (we) lost saw the deceased alive on 10-16-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. PAREKH MD.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-16-80.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1131 Belair Rd Bel Air MD 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/80		23c. NAME OF CEMETERY OR CREMATORY Bel Air Maus. Gardens		23d. LOCATION CITY OR TOWN Harford COUNTY MD.	
24 FUNERAL DIRECTOR NAME Tarnish Funeral Home - Aberdeen, Maryland.				25a. DATE REC'D BY REGISTRAR OCT 27 1980		25b. REGISTRAR'S SIGNATURE R. J. Kelly	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 0 2 6 2 3 1		
1 - STATE REGISTRAR					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Julia (nmn) Russel Ade</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct. 14 80</i>		2b. HOUR <i>12 21 PM</i>		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Aug. 6, 1901</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.	
10 CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hosp.</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>--</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Joppa</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph -- Witcfski</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY -- Bobbin</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO <i>181-26-9765</i>	
17 INFORMANT <i>Mrs. Eva M. Kowalesky</i>		18 ADDRESS <i>909 Greenfield Rd. Joppa, Md.</i>		19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulm. arrest</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHF, arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ch open c mitral, widish</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-22</i> 19 <i>80</i> , to <i>10-14</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10-14</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. N. Calow</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-14-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. N. CALOW</i>		22e. ADDRESS <i>611 S. UNION AVE, HARFORD, MD. 21075</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>Oct. 14, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Preisigacher F.H. Tower City, Schuylkill Pa.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i>				ADDRESS <i>Abingdon, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 15 1980</i>	
25b. REGISTRAR'S SIGNATURE <i>Harry McBrady</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
(TYPE OR PRINT) DIXIE IRENE SCOVITCH 10 15 80 3:55PM

3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 7. UNDER 1 YEAR 8. UNDER 24 HRS
FEMALE White April 5, 1911 69 YRS. MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina U.S.A. WIDOWED ☒ DIVORCED ☐ HARFORD COUNTY MD.

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
HAVRE DE GRACE CITIZENS NSG. HOME EXECUTIVE SECRETARY County Government

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. INSIDE CITY LIMITS? 13c. STREET ADDRESS
13a. STATE 13b. COUNTY 13c. CITY OR TOWN YES ☐ NO ☒
Maryland Prince Georges County Laurel 3571 Fort Meade Road

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
GROVER CLEVELAND Edwards Cordelia CROUSE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO 17. INFORMANT (Name) ADDRESS
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 212-03-3428 Mr. Floyd Edwards Forest Hill, Maryland 21050

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Decompensation 24 hrs.
4292 DUE TO, OR AS A CONSEQUENCE OF (b) A.S. C.V.D. 2-3 years.
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
C.O.P.D. - advanced emphysema

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒ YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
OR CONTRIBUTING ☐ CAUSE OF DEATH P.M. 19

21d. INJURY OCCURRED 21e. PLACE OF INJURY 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐ [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]

22. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1980 to Oct. 15, 1980, that (I) (we) last saw the deceased alive on Oct. 15, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE 22b. DEGREE 22c. DATE SIGNED
Edward C. Loo, M.D. M.D. 10/16/80
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
EDWARD C. LOO, M.D. Havre de Grace, Ind. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
Burial Oct. 18, 1980 DEER CREEK Meth. Ch. Cen. Forest Hill, Harford Co, Maryland 21014

24. FUNERAL DIRECTOR 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JOSEPH W. FOSTER WEST Broadway & Williams Street OCT 17 1980
John Willie Foster Bel Air, Maryland 21014



NO. 10
10-03-3112
GREAT CLEVELAND BRIDGE
COUNTY
COLUMBIA
EXECUTIVE COUNTY COMMISSION
1321 E. 1st Avenue Road
X

100131880
OCT 13 1980
JAMES E. JONES
2000 W. 1st Ave.
MEXICO CITY, MEXICO
SEP 18 1980
GREAT CLEVELAND BRIDGE
COUNTY
COLUMBIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 2 6 2 3 3			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
EMORY Wadde II SHEPARD				October 24, 1980 11 55 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		White		1 15 1917		63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
North Carolina		USA				HARFORD MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Harford Grace		HARFORD MEMORIAL HOSPITAL				Machinist	
12b. KIND OF BUSINESS OR INDUSTRY		Western Elec.					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Md				Harford		Jarrettsville	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Dennis Arthur Shepard				Lula Weets			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				251-10-3070		4117 Federal Hill Road 21084 Dennis W. Shepard-Jarrettsville, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Hepatic Coma							
5715 DUE TO, OR AS A CONSEQUENCE OF (b) Micronodular cirrhosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Myocardial infarction, old and recent							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 8, 19 80, to October 24, 19 80, that (I) (we) last saw the deceased alive on October 24, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Ramiro R. Lindado				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
RAMIRO R. LINDADO				HARFORD MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/28/80		Dulaney Valley		Timonium, Baltimore, MD	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				OCT 27 1980		Rita J. Reubeny	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

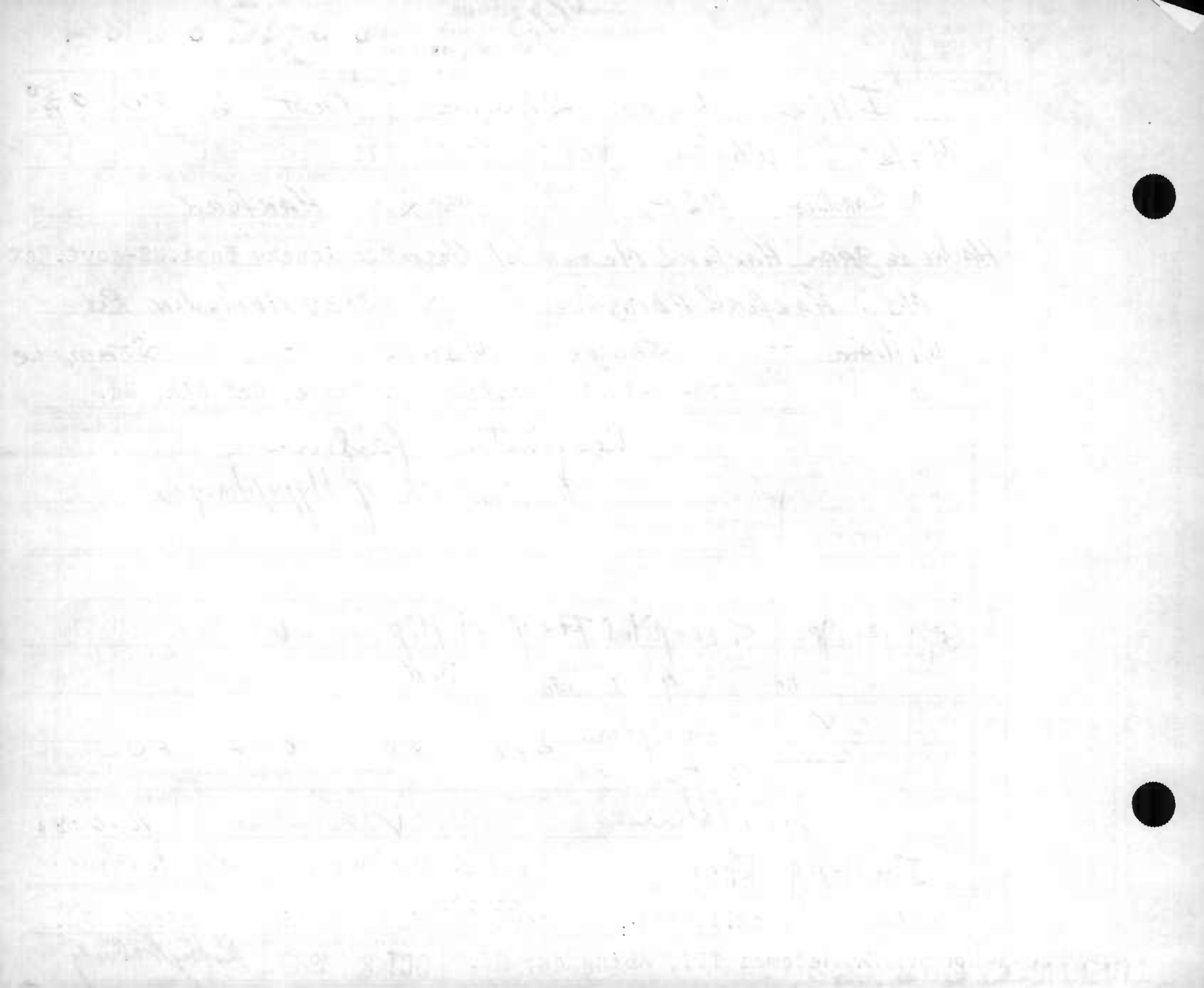
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Illie Lee Shupe</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct 6 80</i>			2b. HOUR MIN <i>9:50 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 10, 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>72</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N. Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD	
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hosp</i>		12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Stationery Engr.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US-govt. Ret</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Abingdon</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William -- Shupe</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maudie -- Stamper</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>218-05-1530</i>		17. INFORMANT ADDRESS <i>Mrs. Helen M. Shupe, Bel Air, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure.</i> <i>1489</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Terminal Ca of Hypopharynx</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION <i>Sept. 2, 1980</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Subcapital Fix of rt. Hip</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9 1 1980</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>Fell.</i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Nursing Home</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>		22a. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> 19 <i>80</i> , to <i>10-6</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10-6</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <i>Jin Hong Rhee</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-6-80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jin Hong Rhee</i>		22e. ADDRESS <i>601 S. Union Ave. Havre de Grace</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 8, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Baptist Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Howard K. McComas III, Abingdon, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 8 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Barbara McNeely</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7026235		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth Irene Siebert</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>OCT. 7, 1980</i>			2b. HOUR <i>7:45</i> M.				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>APRIL 26, 1889</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.		7. # UNDER 1 YEAR MONTHS DAYS		8. # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.						
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>				
13a. STATE <i>MD.</i>					13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Harford</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>666 Lewis St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>EMANUEL PARKER BERRY</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CLARA - WORSHAM</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>213-74-0206</i>		17. INFORMANT <i>CHARLES H. SIEBERT</i>			17. ADDRESS <i>SAME</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10-7-80</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9-30</i> 19 <i>80</i> , to <i>10-7</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10-7</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>[Signature]</i>					DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/7/80</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gunther Hirsch</i>					22e. ADDRESS <i>55 Union Ave Harford de Grace Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>OCT. 10, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>HARFORD DE GRACE HARFORD MD.</i>					
24. FUNERAL DIRECTOR (NAME) <i>R. Madison Mitchell</i>					ADDRESS <i>HARFORD DE GRACE, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 9 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

187

NAME: _____ HOMEWORKER: _____

1
NO
213-24-2206 CHARLES H. SIEBERT
JANE
-
EMANUEL PARKER JERRY CLARK -
WERSHAW

07-11-80 Angel Hill Cem. Hinesdale Grace Hartman No. 10

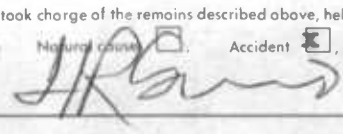
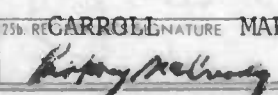
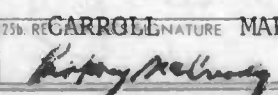
0891 0730

St. Mark's Church, Havre de Grace, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

Items #18a-22a Film 0548 10/30/80 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										26236 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Morris Silver						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 25 1980		2b. HOUR M			
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR JAN. 3, 1927	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 53	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 25 1980		2d. HOUR 1:40A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY <input checked="" type="checkbox"/>						13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5803 HIGHGATE DR. #21215			
14. FATHER'S NAME FIRST SOL LAST ISRAEL			15. MOTHER'S MAIDEN NAME FIRST JULIA MIDDLE SILVER LAST LEVIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 212-22-0062		17. INFORMANT MRS. MARGARET SILVER		ADDRESS 5803 HIGHGATE DR. BALTO., MD 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:10 10/25/ 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET North of 165 CITY OR TOWN Jarrettsville Harf. COUNTY Bo. STATE Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 10/26/80			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE OCT. 27, 1980				23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park			
23d. LOCATION CITY OR TOWN SVANVILLE COUNTY CARROLL STATE MARYLAND				23e. DATE RECORDED OCT 28 1980				23f. RECORDED SIGNATURE 			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				24b. DATE RECORDED OCT 28 1980				24c. RECORDED SIGNATURE 			

REVISED

DATE

1961-10-10

1961-10-10

1961-10-10

1961-10-10

1961-10-10

1961-10-10

TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 6 2 3 7

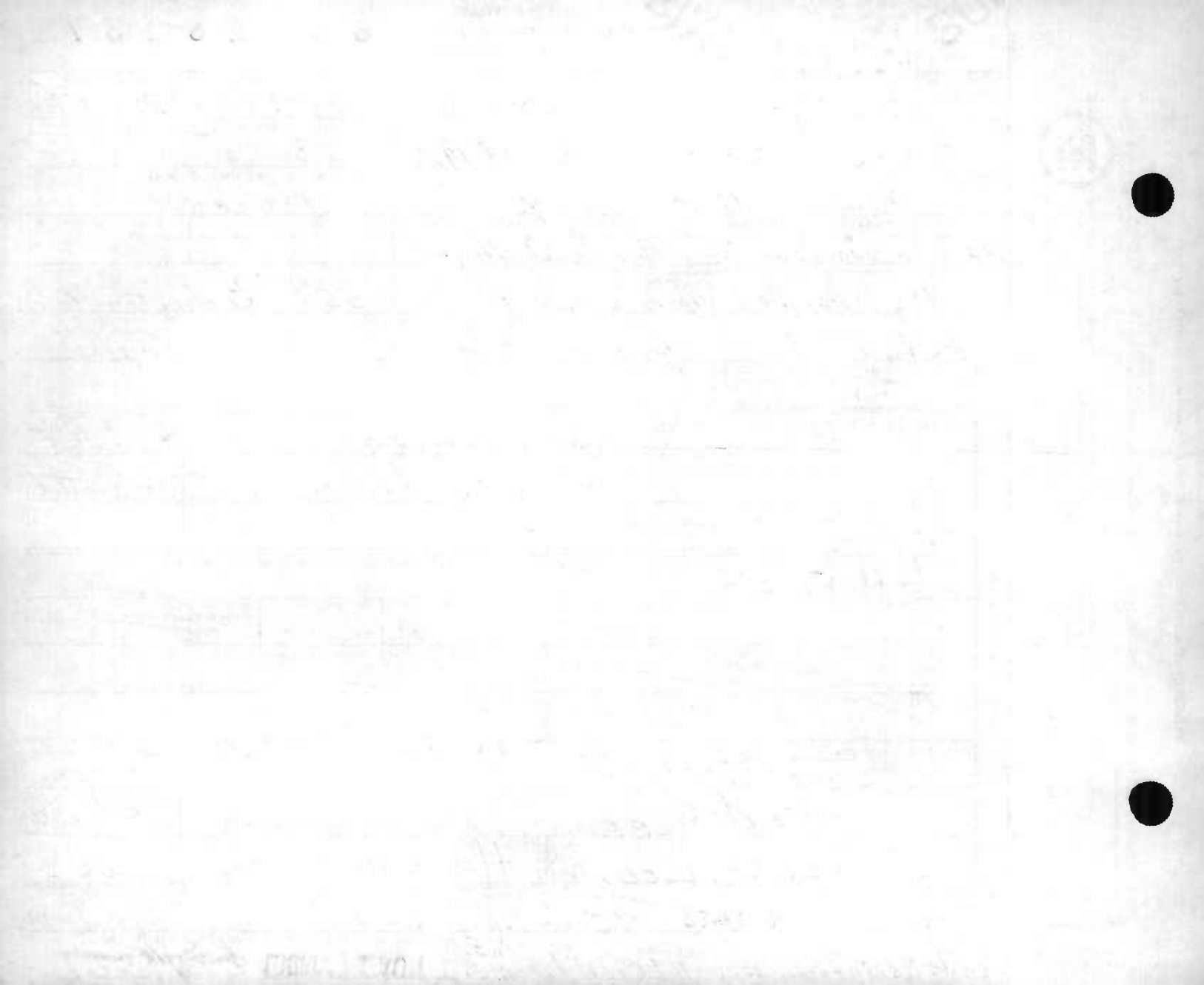
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha Smith			2a. DATE OF DEATH MONTH DAY YEAR OCT. 23 80			2b. HOUR 1:25 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 23 1922		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
12. CITY OR TOWN OF DEATH HAURE DE GRACE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hosp.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY HARFORD 13c. CITY OR TOWN HAURE DE GRACE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS 552 Pennington Ave.							
18. FATHER'S NAME FIRST Arthur MIDDLE HAWKINS LAST Smith		19. MOTHER'S MAIDEN NAME FIRST EVA MIDDLE Taylor LAST Taylor		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21. SOCIAL SECURITY NO.		22. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 26 months	
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19a. DATE OF OPERATION Oct. 22 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. of lung		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 22 1980 to Oct. 23 1980 , that (I) (we) last saw the deceased alive on Oct. 23 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/23/80	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.		23b. ADDRESS HAURE DE GRACE, Ind.					

23a. BURIAL, CREMATION, REMOVAL (MORTUARY) Burial		23b. DATE 10-29-80		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE HAURE DE GRACE HARFORD MD	
24. FUNERAL DIRECTOR NAME ARNOLD BEARD Funeral Ser.		ADDRESS 117 Cecil Ave. Md.		25a. DATE REC'D. BY REGISTRAR NOV 7 1980		25b. REGISTRAR'S SIGNATURE Robert M. Brady	





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Noomi G. Smith			2a. DATE OF DEATH MONTH DAY YEAR 10 17 80			2b. HOUR 9 ³⁰ A M	
3 SEX F		4 RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 11 22 13		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.	
10 CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY -		13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Wright		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret - Blanchard		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-36-1598	
17. INFORMANT N. Jean Kanschat, dgthr., same address		18. STREET ADDRESS 917 N. Belnord Ave, 21205		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS 917 N. Belnord Ave, 21205	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Lung, Chronic Obstructive Pulmonary Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Perforated Duodenal Ulcer. Severe Rheumatoid Arthritis

19a. DATE OF OPERATION 10/7/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Duodenal Ulcer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 8:01/4 1980, to 10/17 1980, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Willard P. Amoss	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amoss		22d. ADDRESS 2404 Pleasantville Rd, Fallston Md		22e. DATE SIGNED 10/17/80		22f. DEGREE MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/80		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. DATE RECEIVED BY REGISTRAR OCT 21 1980		25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S NAME [Name]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10 17 80

HARTFORD

HARTFORD HOSPITAL

OCT 17 1980

[Handwritten signature]

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 26239																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. DATE OF DEATH		2e. DATE OF DEATH		2f. DATE OF DEATH		2g. DATE OF DEATH		2h. DATE OF DEATH		2i. DATE OF DEATH		2j. DATE OF DEATH		2k. DATE OF DEATH		2l. DATE OF DEATH		2m. DATE OF DEATH		2n. DATE OF DEATH		2o. DATE OF DEATH		2p. DATE OF DEATH		2q. DATE OF DEATH		2r. DATE OF DEATH		2s. DATE OF DEATH		2t. DATE OF DEATH		2u. DATE OF DEATH		2v. DATE OF DEATH		2w. DATE OF DEATH		2x. DATE OF DEATH		2y. DATE OF DEATH		2z. DATE OF DEATH		2aa. DATE OF DEATH		2ab. DATE OF DEATH		2ac. DATE OF DEATH		2ad. DATE OF DEATH		2ae. DATE OF DEATH		2af. DATE OF DEATH		2ag. DATE OF DEATH		2ah. DATE OF DEATH		2ai. DATE OF DEATH		2aj. DATE OF DEATH		2ak. DATE OF DEATH		2al. DATE OF DEATH		2am. DATE OF DEATH		2an. DATE OF DEATH		2ao. DATE OF DEATH		2ap. DATE OF DEATH		2aq. DATE OF DEATH		2ar. DATE OF DEATH		2as. DATE OF DEATH		2at. DATE OF DEATH		2au. DATE OF DEATH		2av. DATE OF DEATH		2aw. DATE OF DEATH		2ax. DATE OF DEATH		2ay. DATE OF DEATH		2az. DATE OF DEATH		2ba. DATE OF DEATH		2bb. DATE OF DEATH		2bc. DATE OF DEATH		2bd. DATE OF DEATH		2be. DATE OF DEATH		2bf. DATE OF DEATH		2bg. DATE OF DEATH		2bh. DATE OF DEATH		2bi. DATE OF DEATH		2bj. DATE OF DEATH		2bk. DATE OF DEATH		2bl. DATE OF DEATH		2bm. DATE OF DEATH		2bn. DATE OF DEATH		2bo. DATE OF DEATH		2bp. DATE OF DEATH		2bq. DATE OF DEATH		2br. DATE OF DEATH		2bs. DATE OF DEATH		2bt. DATE OF DEATH		2bu. DATE OF DEATH		2bv. DATE OF DEATH		2bw. DATE OF DEATH		2bx. DATE OF DEATH		2by. DATE OF DEATH		2bz. DATE OF DEATH		2ca. DATE OF DEATH		2cb. DATE OF DEATH		2cc. DATE OF DEATH		2cd. DATE OF DEATH		2ce. DATE OF DEATH		2cf. DATE OF DEATH		2cg. DATE OF DEATH		2ch. DATE OF DEATH		2ci. DATE OF DEATH		2cj. DATE OF DEATH		2ck. DATE OF DEATH		2cl. DATE OF DEATH		2cm. DATE OF DEATH		2cn. DATE OF DEATH		2co. DATE OF DEATH		2cp. DATE OF DEATH		2cq. DATE OF DEATH		2cr. DATE OF DEATH		2cs. DATE OF DEATH		2ct. DATE OF DEATH		2cu. DATE OF DEATH		2cv. DATE OF DEATH		2cw. DATE OF DEATH		2cx. DATE OF DEATH		2cy. DATE OF DEATH		2cz. DATE OF DEATH		2da. DATE OF DEATH		2db. DATE OF DEATH		2dc. DATE OF DEATH		2dd. DATE OF DEATH		2de. DATE OF DEATH		2df. DATE OF DEATH		2dg. DATE OF DEATH		2dh. DATE OF DEATH		2di. DATE OF DEATH		2dj. DATE OF DEATH		2dk. DATE OF DEATH		2dl. DATE OF DEATH		2dm. DATE OF DEATH		2dn. DATE OF DEATH		2do. DATE OF DEATH		2dp. DATE OF DEATH		2dq. DATE OF DEATH		2dr. DATE OF DEATH		2ds. DATE OF DEATH		2dt. DATE OF DEATH		2du. DATE OF DEATH		2dv. DATE OF DEATH		2dw. DATE OF DEATH		2dx. DATE OF DEATH		2dy. DATE OF DEATH		2dz. DATE OF DEATH		2ea. DATE OF DEATH		2eb. DATE OF DEATH		2ec. DATE OF DEATH		2ed. DATE OF DEATH		2ee. DATE OF DEATH		2ef. DATE OF DEATH		2eg. DATE OF DEATH		2eh. DATE OF DEATH		2ei. DATE OF DEATH		2ej. DATE OF DEATH		2ek. DATE OF DEATH		2el. DATE OF DEATH		2em. DATE OF DEATH		2en. DATE OF DEATH		2eo. DATE OF DEATH		2ep. DATE OF DEATH		2eq. DATE OF DEATH		2er. DATE OF DEATH		2es. DATE OF DEATH		2et. DATE OF DEATH		2eu. DATE OF DEATH		2ev. DATE OF DEATH		2ew. DATE OF DEATH		2ex. DATE OF DEATH		2ey. DATE OF DEATH		2ez. DATE OF DEATH		2fa. DATE OF DEATH		2fb. DATE OF DEATH		2fc. DATE OF DEATH		2fd. DATE OF DEATH		2fe. DATE OF DEATH		2ff. DATE OF DEATH		2fg. DATE OF DEATH		2fh. DATE OF DEATH		2fi. DATE OF DEATH		2fj. DATE OF DEATH		2fk. DATE OF DEATH		2fl. DATE OF DEATH		2fm. DATE OF DEATH		2fn. DATE OF DEATH		2fo. DATE OF DEATH		2fp. DATE OF DEATH		2fq. DATE OF DEATH		2fr. DATE OF DEATH		2fs. DATE OF DEATH		2ft. DATE OF DEATH		2fu. DATE OF DEATH		2fv. DATE OF DEATH		2fw. DATE OF DEATH		2fx. DATE OF DEATH		2fy. DATE OF DEATH		2fz. DATE OF DEATH		2ga. DATE OF DEATH		2gb. DATE OF DEATH		2gc. DATE OF DEATH		2gd. DATE OF DEATH		2ge. DATE OF DEATH		2gf. DATE OF DEATH		2gg. DATE OF DEATH		2gh. DATE OF DEATH		2gi. DATE OF DEATH		2gj. DATE OF DEATH		2gk. DATE OF DEATH		2gl. DATE OF DEATH		2gm. DATE OF DEATH		2gn. DATE OF DEATH		2go. DATE OF DEATH		2gp. DATE OF DEATH		2gq. DATE OF DEATH		2gr. DATE OF DEATH		2gs. DATE OF DEATH		2gt. DATE OF DEATH		2gu. DATE OF DEATH		2gv. DATE OF DEATH		2gw. DATE OF DEATH		2gx. DATE OF DEATH		2gy. DATE OF DEATH		2gz. DATE OF DEATH		2ha. DATE OF DEATH		2hb. DATE OF DEATH		2hc. DATE OF DEATH		2hd. DATE OF DEATH		2he. DATE OF DEATH		2hf. DATE OF DEATH		2hg. DATE OF DEATH		2hh. DATE OF DEATH		2hi. DATE OF DEATH		2hj. DATE OF DEATH		2hk. DATE OF DEATH		2hl. DATE OF DEATH		2hm. DATE OF DEATH		2hn. DATE OF DEATH		2ho. DATE OF DEATH		2hp. DATE OF DEATH		2hq. DATE OF DEATH		2hr. DATE OF DEATH		2hs. DATE OF DEATH		2ht. DATE OF DEATH		2hu. DATE OF DEATH		2hv. DATE OF DEATH		2hw. DATE OF DEATH		2hx. DATE OF DEATH		2hy. DATE OF DEATH		2hz. DATE OF DEATH		2ia. DATE OF DEATH		2ib. DATE OF DEATH		2ic. DATE OF DEATH		2id. DATE OF DEATH		2ie. DATE OF DEATH		2if. DATE OF DEATH		2ig. DATE OF DEATH		2ih. DATE OF DEATH		2ii. DATE OF DEATH		2ij. DATE OF DEATH		2ik. DATE OF DEATH		2il. DATE OF DEATH		2im. DATE OF DEATH		2in. DATE OF DEATH		2io. DATE OF DEATH		2ip. DATE OF DEATH		2iq. DATE OF DEATH		2ir. DATE OF DEATH		2is. DATE OF DEATH		2it. DATE OF DEATH		2iu. DATE OF DEATH		2iv. DATE OF DEATH		2iw. DATE OF DEATH		2ix. DATE OF DEATH		2iy. DATE OF DEATH		2iz. DATE OF DEATH		2ja. DATE OF DEATH		2jb. DATE OF DEATH		2jc. DATE OF DEATH		2jd. DATE OF DEATH		2je. DATE OF DEATH		2jf. DATE OF DEATH		2jg. DATE OF DEATH		2jh. DATE OF DEATH		2ji. DATE OF DEATH		2jj. DATE OF DEATH		2jk. DATE OF DEATH		2jl. DATE OF DEATH		2jm. DATE OF DEATH		2jn. DATE OF DEATH		2jo. DATE OF DEATH		2jp. DATE OF DEATH		2jq. DATE OF DEATH		2jr. DATE OF DEATH		2js. DATE OF DEATH		2jt. DATE OF DEATH		2ju. DATE OF DEATH		2jv. DATE OF DEATH		2jw. DATE OF DEATH		2jx. DATE OF DEATH		2jy. DATE OF DEATH		2jz. DATE OF DEATH		2ka. DATE OF DEATH		2kb. DATE OF DEATH		2kc. DATE OF DEATH		2kd. DATE OF DEATH		2ke. DATE OF DEATH		2kf. DATE OF DEATH		2kg. DATE OF DEATH		2kh. DATE OF DEATH		2ki. DATE OF DEATH		2kj. DATE OF DEATH		2kk. DATE OF DEATH		2kl. DATE OF DEATH		2km. DATE OF DEATH		2kn. DATE OF DEATH		2ko. DATE OF DEATH		2kp. DATE OF DEATH		2kq. DATE OF DEATH		2kr. DATE OF DEATH		2ks. DATE OF DEATH		2kt. DATE OF DEATH		2ku. DATE OF DEATH		2kv. DATE OF DEATH		2kw. DATE OF DEATH		2kx. DATE OF DEATH		2ky. DATE OF DEATH		2kz. DATE OF DEATH		2la. DATE OF DEATH		2lb. DATE OF DEATH		2lc. DATE OF DEATH		2ld. DATE OF DEATH		2le. DATE OF DEATH		2lf. DATE OF DEATH		2lg. DATE OF DEATH		2lh. DATE OF DEATH		2li. DATE OF DEATH		2lj. DATE OF DEATH		2lk. DATE OF DEATH		2ll. DATE OF DEATH		2lm. DATE OF DEATH		2ln. DATE OF DEATH		2lo. DATE OF DEATH		2lp. DATE OF DEATH		2lq. DATE OF DEATH		2lr. DATE OF DEATH		2ls. DATE OF DEATH		2lt. DATE OF DEATH		2lu. DATE OF DEATH		2lv. DATE OF DEATH		2lw. DATE OF DEATH		2lx. DATE OF DEATH		2ly. DATE OF DEATH		2lz. DATE OF DEATH		2ma. DATE OF DEATH		2mb. DATE OF DEATH		2mc. DATE OF DEATH		2md. DATE OF DEATH		2me. DATE OF DEATH		2mf. DATE OF DEATH		2mg. DATE OF DEATH		2mh. DATE OF DEATH		2mi. DATE OF DEATH		2mj. DATE OF DEATH		2mk. DATE OF DEATH		2ml. DATE OF DEATH		2mn. DATE OF DEATH		2mo. DATE OF DEATH		2mp. DATE OF DEATH		2mq. DATE OF DEATH		2mr. DATE OF DEATH		2ms. DATE OF DEATH		2mt. DATE OF DEATH		2mu. DATE OF DEATH		2mv. DATE OF DEATH		2mw. DATE OF DEATH		2mx. DATE OF DEATH		2my. DATE OF DEATH		2mz. DATE OF DEATH		2na. DATE OF DEATH		2nb. DATE OF DEATH		2nc. DATE OF DEATH		2nd. DATE OF DEATH		2ne. DATE OF DEATH		2nf. DATE OF DEATH		2ng. DATE OF DEATH		2nh. DATE OF DEATH		2ni. DATE OF DEATH		2nj. DATE OF DEATH		2nk. DATE OF DEATH		2nl. DATE OF DEATH		2nm. DATE OF DEATH		2nn. DATE OF DEATH		2no. DATE OF DEATH		2np. DATE OF DEATH		2nq. DATE OF DEATH		2nr. DATE OF DEATH		2ns. DATE OF DEATH		2nt. DATE OF DEATH		2nu. DATE OF DEATH		2nv. DATE OF DEATH		2nw. DATE OF DEATH		2nx. DATE OF DEATH		2ny. DATE OF DEATH		2nz. DATE OF DEATH		2oa. DATE OF DEATH		2ob. DATE OF DEATH		2oc. DATE OF DEATH		2od. DATE OF DEATH		2oe. DATE OF DEATH		2of. DATE OF DEATH		2og. DATE OF DEATH		2oh. DATE OF DEATH		2oi. DATE OF DEATH		2oj. DATE OF DEATH		2ok. DATE OF DEATH		2ol. DATE OF DEATH		2om. DATE OF DEATH		2on. DATE OF DEATH		2oo. DATE OF DEATH		2op. DATE OF DEATH		2oq. DATE OF DEATH		2or. DATE OF DEATH		2os. DATE OF DEATH		2ot. DATE OF DEATH		2ou. DATE OF DEATH		2ov. DATE OF DEATH		2ow. DATE OF DEATH		2ox. DATE OF DEATH		2oy. DATE OF DEATH		2oz. DATE OF DEATH		2pa. DATE OF DEATH		2pb. DATE OF DEATH		2pc. DATE OF DEATH		2pd. DATE OF DEATH		2pe. DATE OF DEATH		2pf. DATE OF DEATH		2pg. DATE OF DEATH		2ph. DATE OF DEATH		2pi. DATE OF DEATH		2pj. DATE OF DEATH		2pk. DATE OF DEATH		2pl. DATE OF DEATH		2pm. DATE OF DEATH		2pn. DATE OF DEATH		2po. DATE OF DEATH		2pp. DATE OF DEATH		2pq. DATE OF DEATH		2pr. DATE OF DEATH		2ps. DATE OF DEATH		2pt. DATE OF DEATH		2pu. DATE OF DEATH		2pv. DATE OF DEATH		2pw. DATE OF DEATH		2px. DATE OF DEATH		2py. DATE OF DEATH		2pz. DATE OF DEATH		2qa. DATE OF DEATH		2qb. DATE OF DEATH		2qc. DATE OF DEATH		2qd. DATE OF DEATH		2qe. DATE OF DEATH		2qf. DATE OF DEATH		2qg. DATE OF DEATH		2qh. DATE OF DEATH		2qi. DATE OF DEATH		2qj. DATE OF DEATH		2qk. DATE OF DEATH		2ql. DATE OF DEATH		2qm. DATE OF DEATH		2qn. DATE OF DEATH		2qo. DATE OF DEATH		2qp. DATE OF DEATH		2qq. DATE OF DEATH		2qr. DATE OF DEATH		2qs. DATE OF DEATH		2qt. DATE OF DEATH		2qu. DATE OF DEATH		2qv. DATE OF DEATH		2qw. DATE OF DEATH		2qx. DATE OF DEATH		2qy. DATE OF DEATH		2qz. DATE OF DEATH		2ra. DATE OF DEATH		2rb. DATE OF DEATH		2rc. DATE OF DEATH		2rd. DATE OF DEATH		2re. DATE OF DEATH		2rf. DATE OF DEATH		2rg. DATE OF DEATH		2rh. DATE OF DEATH		2ri. DATE OF DEATH		2rj. DATE OF DEATH		2rk. DATE OF DEATH		2rl. DATE OF DEATH		2rm. DATE OF DEATH		2rn. DATE OF DEATH		2ro. DATE OF DEATH		2rp. DATE OF DEATH		2rq. DATE OF DEATH		2rr. DATE OF DEATH		2rs. DATE OF DEATH		2rt. DATE OF DEATH		2ru. DATE OF DEATH		2rv. DATE OF DEATH		2rw. DATE OF DEATH		2rx. DATE OF DEATH		2ry. DATE OF DEATH		2rz. DATE OF DEATH		2sa. DATE OF DEATH		2sb. DATE OF DEATH		2sc. DATE OF DEATH		2sd. DATE OF DEATH		2se. DATE OF DEATH		2sf. DATE OF DEATH		2sg. DATE OF DEATH		2sh. DATE OF DEATH		2si. DATE OF DEATH		2sj. DATE OF DEATH		2sk. DATE OF DEATH		2sl. DATE OF DEATH		2sm. DATE OF DEATH		2sn. DATE OF DEATH		2so. DATE OF DEATH		2sp. DATE OF DEATH		2sq. DATE OF DEATH		2sr. DATE OF DEATH		2ss. DATE OF DEATH		2st. DATE OF DEATH		2su. DATE OF DEATH		2sv. DATE OF DEATH		2sw. DATE OF DEATH		2sx. DATE OF DEATH		2sy. DATE OF DEATH		2sz. DATE OF DEATH		2ta. DATE OF DEATH		2tb. DATE OF DEATH		2tc. DATE OF DEATH		2td. DATE OF DEATH		2te. DATE OF DEATH		2tf. DATE OF DEATH		2tg. DATE OF DEATH		2th. DATE OF DEATH		2ti. DATE OF DEATH		2tj. DATE OF DEATH		2tk. DATE OF DEATH		2tl. DATE OF DEATH		2tm. DATE OF DEATH		2tn. DATE OF DEATH		2to. DATE OF DEATH		2tp. DATE OF DEATH		2tq. DATE OF DEATH		2tr. DATE OF DEATH		2ts. DATE OF DEATH		2tt. DATE OF DEATH		2tu. DATE OF DEATH		2tv. DATE OF DEATH		2tw. DATE OF DEATH		2tx. DATE OF DEATH		2ty. DATE OF DEATH		2tz. DATE OF DEATH		2ua. DATE OF DEATH		2ub. DATE OF DEATH		2uc. DATE OF DEATH		2ud. DATE OF DEATH		2ue. DATE OF DEATH		2uf. DATE OF DEATH		2ug. DATE OF DEATH		2uh. DATE OF DEATH		2ui. DATE OF DEATH		2uj. DATE OF DEATH		2uk. DATE OF DEATH		2ul. DATE OF DEATH		2um. DATE OF DEATH		2un. DATE OF DEATH		2uo. DATE OF DEATH		2up. DATE OF DEATH		2uq. DATE OF DEATH		2ur. DATE OF DEATH		2us. DATE OF DEATH		2ut. DATE OF DEATH		2uu. DATE OF DEATH		2uv. DATE OF DEATH		2uw. DATE OF DEATH		2ux. DATE OF DEATH		2uy. DATE OF DEATH		2uz. DATE OF DEATH		2va. DATE OF DEATH		2vb. DATE OF DEATH		2vc. DATE OF DEATH		2vd. DATE OF DEATH		2ve. DATE OF DEATH		2vf. DATE OF DEATH		2vg. DATE OF DEATH		2vh. DATE OF DEATH		2vi. DATE OF DEATH		2vj. DATE OF DEATH		2vk. DATE OF DEATH		2vl. DATE OF DEATH		2vm. DATE OF DEATH		2vn. DATE OF DEATH		2vo. DATE OF DEATH		2vp. DATE OF DEATH		2vq. DATE OF DEATH		2vr. DATE OF DEATH		2vs. DATE OF DEATH		2vt. DATE OF DEATH		2vu. DATE OF DEATH		2vv. DATE OF DEATH		2vw. DATE OF DEATH		2vx. DATE OF DEATH		2vy. DATE OF DEATH		2vz. DATE OF DEATH		2wa. DATE OF DEATH		2wb. DATE OF DEATH		2wc. DATE OF DEATH		2wd. DATE OF DEATH		2we. DATE OF DEATH		2wf. DATE OF DEATH		2wg. DATE OF DEATH		2wh. DATE OF DEATH		2wi. DATE OF DEATH		2wj. DATE OF DEATH		2wk. DATE OF DEATH		2wl. DATE OF DEATH		2wm. DATE OF DEATH		2wn. DATE OF DEATH		2wo. DATE OF DEATH		2wp. DATE OF DEATH		2wq. DATE OF DEATH		2wr. DATE OF DEATH		2ws. DATE OF DEATH		2wt. DATE OF DEATH		2wu. DATE OF DEATH		2wv. DATE OF DEATH		2ww. DATE OF DEATH		2wx. DATE OF DEATH		2wy. DATE OF DEATH		2wz. DATE OF DEATH		2xa. DATE OF DEATH		2xb. DATE OF DEATH		2xc. DATE OF DEATH		2xd. DATE OF DEATH		2xe. DATE OF DEATH		2xf. DATE OF DEATH		2xg. DATE OF DEATH		2xh. DATE OF DEATH		2xi. DATE OF DEATH		2xj. DATE OF DEATH		2xk. DATE OF DEATH		2xl. DATE OF DEATH		2xm. DATE OF DEATH		2xn. DATE OF DEATH		2xo. DATE OF DEATH		2xp. DATE OF DEATH		2xq. DATE OF DEATH		2xr. DATE OF DEATH		2xs. DATE OF DEATH		2xt. DATE OF DEATH		2xu. DATE OF DEATH		2xv. DATE OF DEATH		2xw. DATE OF DEATH		2xx. DATE OF DEATH		2xy. DATE OF DEATH		2xz. DATE OF DEATH		2ya. DATE OF DEATH		2yb. DATE OF DEATH		2yc. DATE OF DEATH		2yd. DATE OF DEATH		2ye. DATE OF DEATH		2yf. DATE OF DEATH		2yg. DATE OF DEATH		2yh. DATE OF DEATH		2yi. DATE OF DEATH		2yj. DATE OF DEATH		2yk. DATE OF DEATH		2yl. DATE OF DEATH		2ym. DATE OF DEATH		2yn. DATE OF DEATH		2yo. DATE OF DEATH		2yp. DATE OF DEATH		2yq. DATE OF DEATH		2yr. DATE OF DEATH		2ys. DATE OF DEATH		2yt. DATE OF DEATH		2yu. DATE OF DEATH		2yv. DATE OF DEATH		2yw. DATE OF DEATH		2yx. DATE OF DEATH		2yy. DATE OF DEATH		2yz. DATE OF DEATH		2za. DATE OF DEATH		2zb. DATE OF DEATH		2zc. DATE OF DEATH		2zd. DATE OF DEATH		2ze. DATE OF DEATH		2zf. DATE OF DEATH		2zg. DATE OF DEATH		2zh. DATE OF DEATH		2zi. DATE OF DEATH		2zj. DATE OF DEATH		2zk. DATE OF DEATH		2zl. DATE OF DEATH		2zm. DATE OF DEATH		2zn. DATE OF DEATH		2zo. DATE OF DEATH		2zp. DATE OF DEATH		2zq. DATE OF DEATH		2zr. DATE OF DEATH		2zs. DATE OF DEATH		2zt. DATE OF DEATH		2zu. DATE OF DEATH		2zv. DATE OF DEATH		2zw. DATE OF DEATH		2zx. DATE OF DEATH		2zy. DATE OF DEATH		2zz. DATE OF DEATH	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of head 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30x 10-8-1980	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET Johnson Mill Rd. e. of Chestnut Hill	CITY OR TOWN Harford COUNTY Md.
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ann M. Dixon, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED 10-9-80	
ADDRESS 111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPEC			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maggie M. Sumpter			2a. DATE OF DEATH MONTH DAY YEAR 1 0-31-80			2b. HOUR 2;35 a				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford, Co. MD.				
10. CITY OR TOWN OF DEATH Ha. D. Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nurs ing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 624 Franklin Street	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Thomas Mitchell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jane Howery							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS David G. McGlothlin, Perryville, Maryland.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arrhythmia (c) Myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost above, the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23a. SIGNATURE Dante Monakil						DEGREE		23c. DATE SIGNED 10/31/80		
23b. PHYSICIAN'S NAME (TYPE OR PRINT) DAVE MONAKIL						23d. ADDRESS 622 S. Main St.		23e. CITY OR TOWN Harford, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Nov. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit, Cecil, Maryland.			
24. FUNERAL DIRECTOR NAME Lee A. Patterson & S on, Perryville, Maryland.						25a. DATE REC'D. BY REGISTRAR NOV 6 1980		25b. REGISTRAR'S SIGNATURE Robert E. B.		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 26241							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED	
Betty LUANN Thomas								MONTH DAY YEAR 10 27 80	
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female	White	8/2/56		24 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
M. CAROLINA		USA				Harford County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EDGEWOOD		300 ft. off Winters Run Road						BUS	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS			
MD		BALTO		ROSEDALE		318 LEATHERWOOD PL			
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE LAST	
SETH S. PETERSON						ATHLEEN WILSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
NO		25 70 7239		ROBERT C. THOMAS		ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		2 10 27 80		subject inhaled exhaust fumes from auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
		auto-off road		300 ft. off Winters Run Rd.		Harford		MD.	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER				DATE SIGNED	
Thomas D. Smith, MD.		Deputy Chief						10/28/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Thomas D. Smith, MD.		111 Penn St. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
BURIAL		10/31/80		HOLLY HILL		BALTO.		MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE			
J.E. CONNELLY		300 MACE		NOV 3 1980		Robert McCreedy			

[Faint, illegible handwriting on lined paper]



NOV 2 1980
[Faint, illegible handwriting]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0 2 6 2 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SOPHIE			FIRST Tessie			MIDDLE THOMSON			LAST Thomson			2a. DATE OF DEATH MONTH DAY YEAR 10-20-80			2b. HOUR 11:50PM M				
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH MONTH DAY YEAR 11-7-88			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.			# UNDER 1 YEAR MONTHS DAYS			# UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.										
10 CITY OR TOWN OF DEATH HAVRE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZEN NURS. HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE MARYLAND						13b. COUNTY HARFORD		13c. CITY OR TOWN ABINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4019 EAST BAKER AVENUE 4019 BAKER AVE	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE STIERSTORFER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hoffman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-74-4120						17 INFORMANT (See 676-0609) ADDRESS Mr. Audley J. Thomson 4019 East Baker Avenue Abington, Maryland 21009							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 1990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized carcinoma (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.																			
22b. SIGNATURE [Signature]						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 10/21/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. J. Amato M.D.						22e. ADDRESS 319 So. Union Ave Hvy, Md. 21078													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 23, 1980			23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014										
24. FUNERAL DIRECTOR Joseph William Foster Smithville, Md.						W. Brandy & Williams St. ADDRESS Bel Air, Maryland 21014						25a. DATE REC'D. BY REGISTRAR OCT 24 1980			25b. REGISTRAR'S SIGNATURE [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 6 2 4 3			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Edgar B. WACHTER</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>October 20, 1980</i>				2b. HOUR <i>11⁰⁶ A.M.</i>				
3 SEX <i>male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Nov. 27, 1893</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
2c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>us</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.							
10 CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD MEMORIAL Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Traffic Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Guard</i>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md.</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Havre de Grace</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>109 N. EARLTON RD.</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Wachter</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Albina Koontz</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>					
16b. SOCIAL SECURITY NO. <i>213-18-0797</i>				17. INFORMANT <i>Mrs. Edgar Wachter</i>				ADDRESS <i>Havre de Grace, Md. 21078</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 492- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary acidosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cor Pulmonale - Amphysema</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Pneumonia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>October 5, 1980</i> to <i>October 20, 1980</i> , that (I) (we) last saw the deceased alive on <i>October 19, 1980</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Wm. H. Wachsman</i>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED <i>10/20/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. Wachsman MD.</i>				22e. ADDRESS <i>Havre de Grace, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10/21/1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Smithsburg Crematory</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Smithsburg, Washington, Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Havre de Grace</i> ADDRESS <i>Waynesboro, Penna.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 24 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Barry McCreedy</i>							

NOV. 17, 1953

STATIONER, 100 N. 100 W.

STATIONER

STATIONER

STATIONER

STATIONER

STATIONER, 100 N. 100 W.

NO

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STATIONER, 100 N. 100 W.

STATIONER

STATIONER, 100 N. 100 W.

STATIONER, 100 N. 100 W.

STATIONER, 100 N. 100 W.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

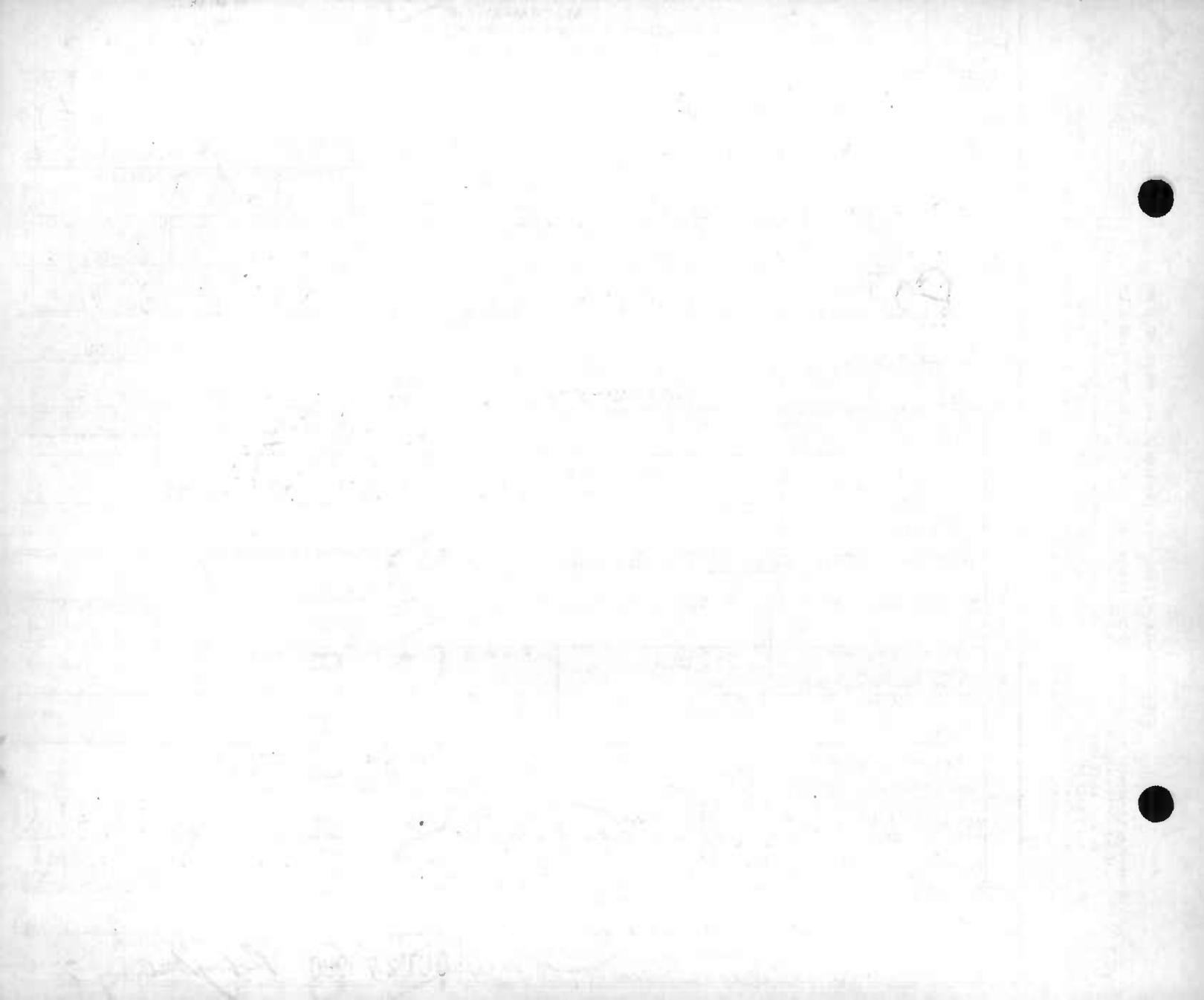
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Elizabeth		MIDDLE A.		LAST Wayne		2b. DATE OF DEATH		KNOWN ESTIMATED		MONTH 10		DAY 22		YEAR 1980		2d. HOUR 2:58 P.M.	
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 11 15 13		6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 10 22 1980		2d. HOUR 2:58 P.M.			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.							
10. CITY OR TOWN OF DEATH FALLSTON, MD.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC							
13a. STATE PA				13b. COUNTY York				13c. CITY OR TOWN Delta				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS RD #2 Box 91			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH STEPHENS															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 203-10-5297				17. INFORMANT ADDRESS HARVEY W. WAYNE, RD #2 Box 91, DELTA, PA.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 } Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) } Cardiac Arrest 2° Ectopy Arteriosclerotic Heart Disease																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE Willard R Amoss				TITLE (SPECIFY) Asst. Dep				MEDICAL EXAMINER				DATE SIGNED 10/22/80							
EXAMINER'S NAME (TYPE OR PRINT) Willard R Amoss				ADDRESS 2404 Pleasantville Rd, Fallston MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE Oct. 25, 1980				23c. NAME OF CEMETERY OR CREMATORY SLATEVILLE CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE DELTA York PENNSYLVANIA							
24. FUNERAL DIRECTOR NAME John H. Harkins				ADDRESS 600 Main St., DELTA, PA. 17314				25a. DATE REC'D. BY REGISTRAR OCT 27 1980				25b. REGISTRAR'S SIGNATURE Kristy McCready							



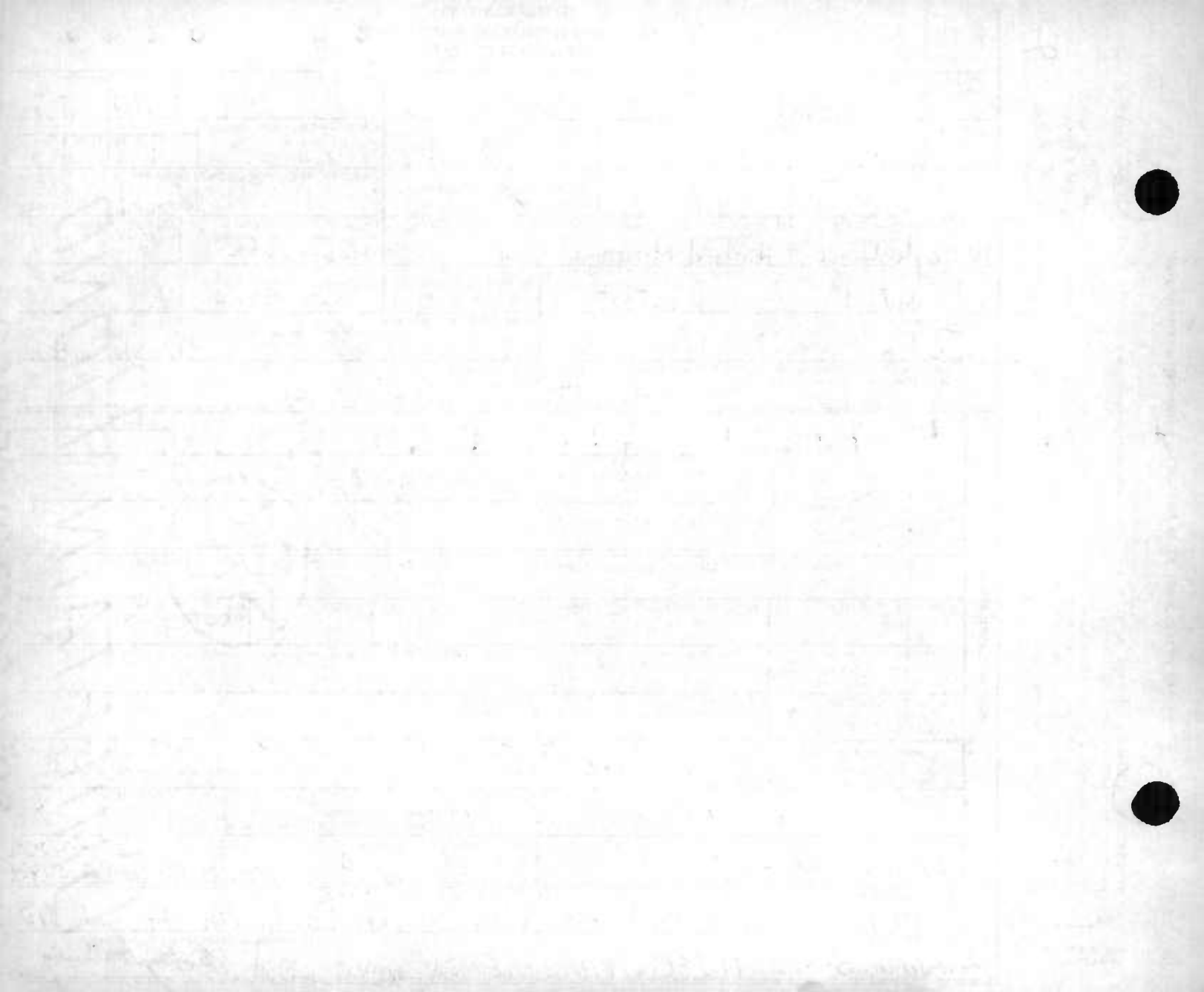
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 0 26245						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Rachel Ann Webster			Oct 29 1980				7:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Negro		1 12 1895		85 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD.		USA				Harford MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hosp				Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Harf		Street		YES <input type="checkbox"/> NO <input type="checkbox"/>		1520 Arena Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
John Hopkins				Anne Washington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				220-01-5379		Earnest Webster			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
2391 } DUE TO, OR AS A CONSEQUENCE OF									Tumor? of l. lung.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									(b)
DUE TO, OR AS A CONSEQUENCE OF									(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9-14 1980, to 10-29 1980, that (I) (we) lost the deceased alive on 10-29 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Lajos Mezei			50. Union Ave Havre de Grace Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		11-1-80		BETHKley Cemetery		City or Town		County State	
						Harford MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arnold W. Beard 117 E Cecil Ave. N.E. MD.				NOV 7 1980		Rita McCreedy			

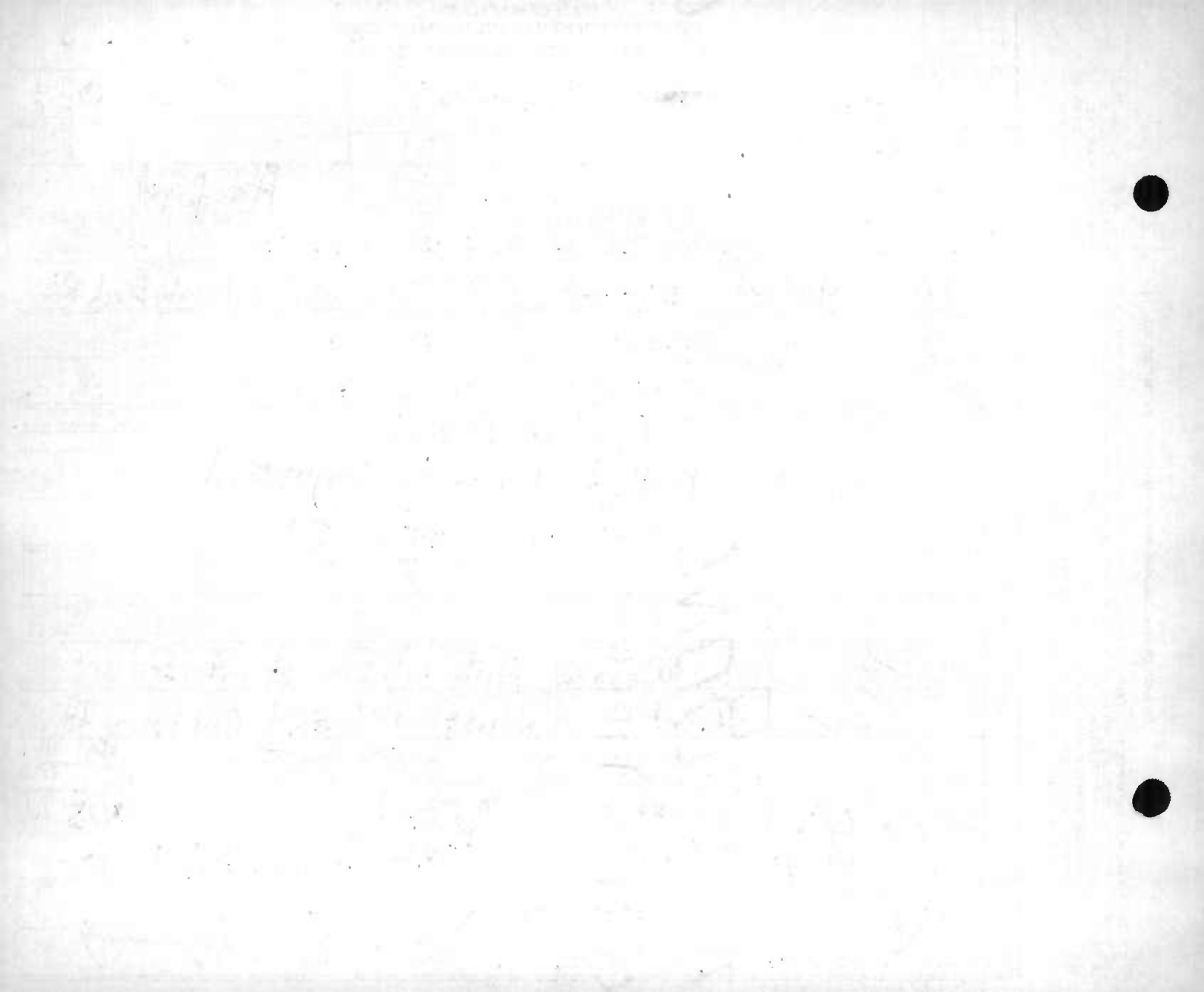


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMM-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26246	
1. DECEASED NAME (TYPE OR PRINT) Ann CHRISTINA Welzenbach							2a. DATE KNOWN OF DEATH MONTH 10 DAY 25 YEAR 1980		2b. HOUR 2:12 P.M.		
3. SEX F	4. RACE Cauc	5. DATE OF BIRTH MONTH Feb. DAY 14 YEAR 1900	6. AGE (IN YEARS) YRS. 80	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD MONTH 10 DAY 25 YEAR 1980		2d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --			
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2800 Willoughby Beech Rd			
14. FATHER'S NAME FIRST George MIDDLE -- LAST Bearsch				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Emma LAST Gunther							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-40-1380		17. INFORMANT ADDRESS Mrs. Gertrude E. Parks, Edgewood, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 8/29 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Multiple Traumatic Injuries of DUE TO, OR AS A CONSEQUENCE OF (c) Head, Chest and Abdomen										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 10 A.M. MONTH 10 DAY 25 YEAR 1980 (P.M.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Auto collision at intersection					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET Route 136 and Cool Springs Rd CITY OR TOWN Harford COUNTY Harford STATE Md					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquest <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Willard P Amoss				TIME (SPECIFY) 10:25				DATE SIGNED 10/25/80			
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss				ADDRESS 2404 Pleasantville Rd, Fallston							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cen.				23d. LOCATION CITY OR TOWN Joppa COUNTY Harford STATE Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas				ADDRESS 111, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR OCT 28 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

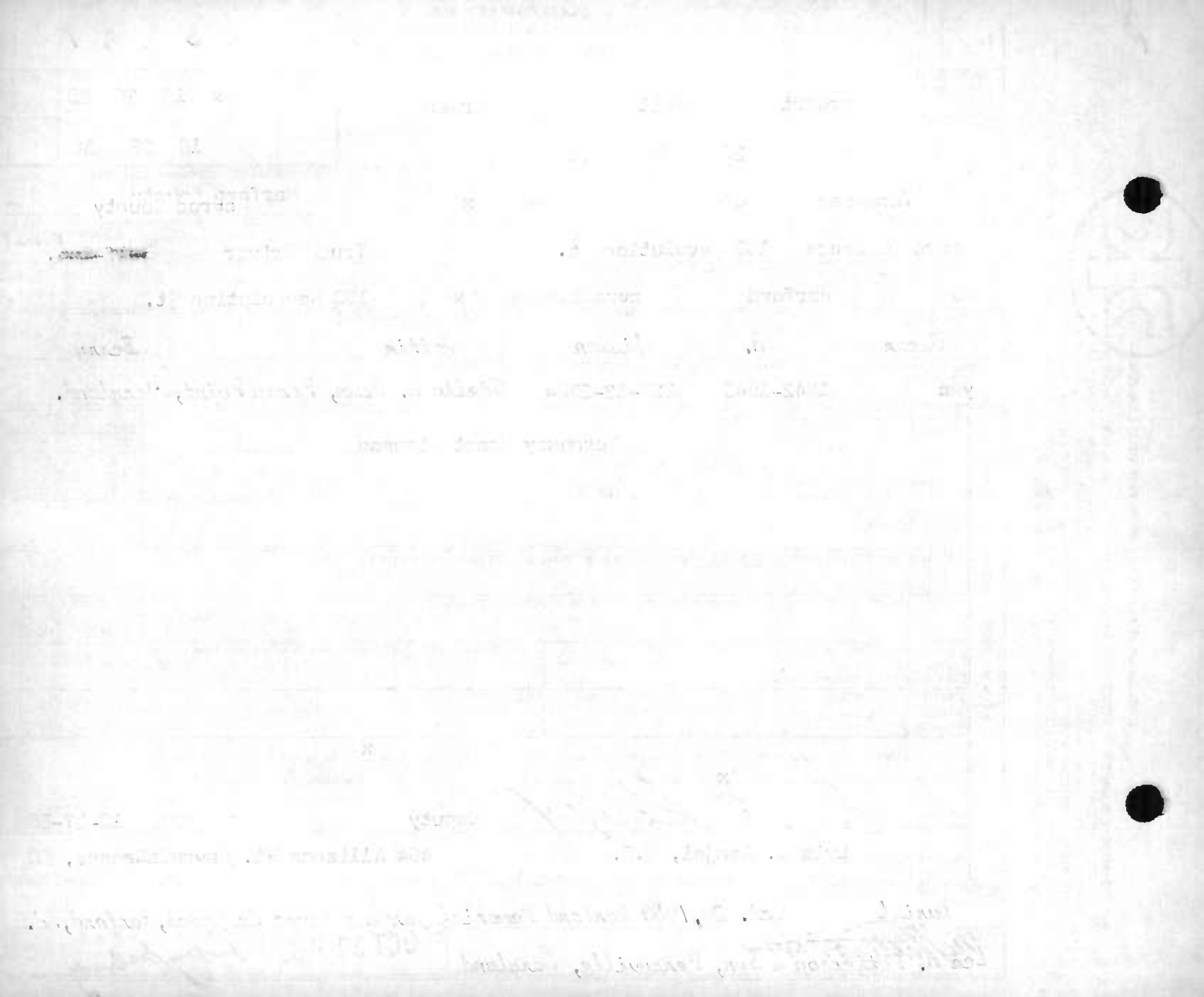


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BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26247	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert Smith Whisman										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 26 80	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9 25 09	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 26 80		2b. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Havre DE Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 Revolution St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Fleets			
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Havre DE Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 Revolution St.			
14. FATHER'S NAME FIRST MIDDLE LAST Oscar A. Whisman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Berry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1942-1945		17. INFORMANT ADDRESS Stella M. Hamm, Perry Point, Maryland.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>ASCVD</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Luis E. Renjel</u>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 10-27-80			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St. Havre DE Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 28, 1980		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Havre DE Grace, Harford, Md.			
24. FUNERAL DIRECTOR'S NAME Lester Patterson & Son				ADDRESS Perryville, Maryland				25a. DATE RECEIVED BY REGISTRAR OCT 31 1980		25b. REGISTRAR'S SIGNATURE [Signature]	





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cornelia Marilyn Williamson		2a. DATE OF DEATH MONTH DAY YEAR 10 02 80		2b. HOUR 3:45A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 22 1920	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2512 Green Spring Avenue		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist/Ct.		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co. P.D.			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppa	
14. FATHER'S NAME FIRST MIDDLE LAST William J O'Neill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose M Mann		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 369-36-5838		17. INFORMANT ADDRESS John W. Williamson 2512 Green Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malignant pleural effusion 1991 DUE TO, OR AS A CONSEQUENCE OF (b) primary site unknown 7 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none					
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 19 September 19 80 to 2 October 19 80 , that (I) (we) last saw the deceased alive on 2 October 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE June E. Fusner		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2 October 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) June E. Fusner		22e. ADDRESS 3685 Sunny Crest Dr. Brookfield WI 53005.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/80		23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	
24. FUNERAL DIRECTOR NAME E.F. Lassahn Funeral Home		ADDRESS 11750 Belair Rd		25a. RECEIVED BY REGISTRAR 8019 580	
25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

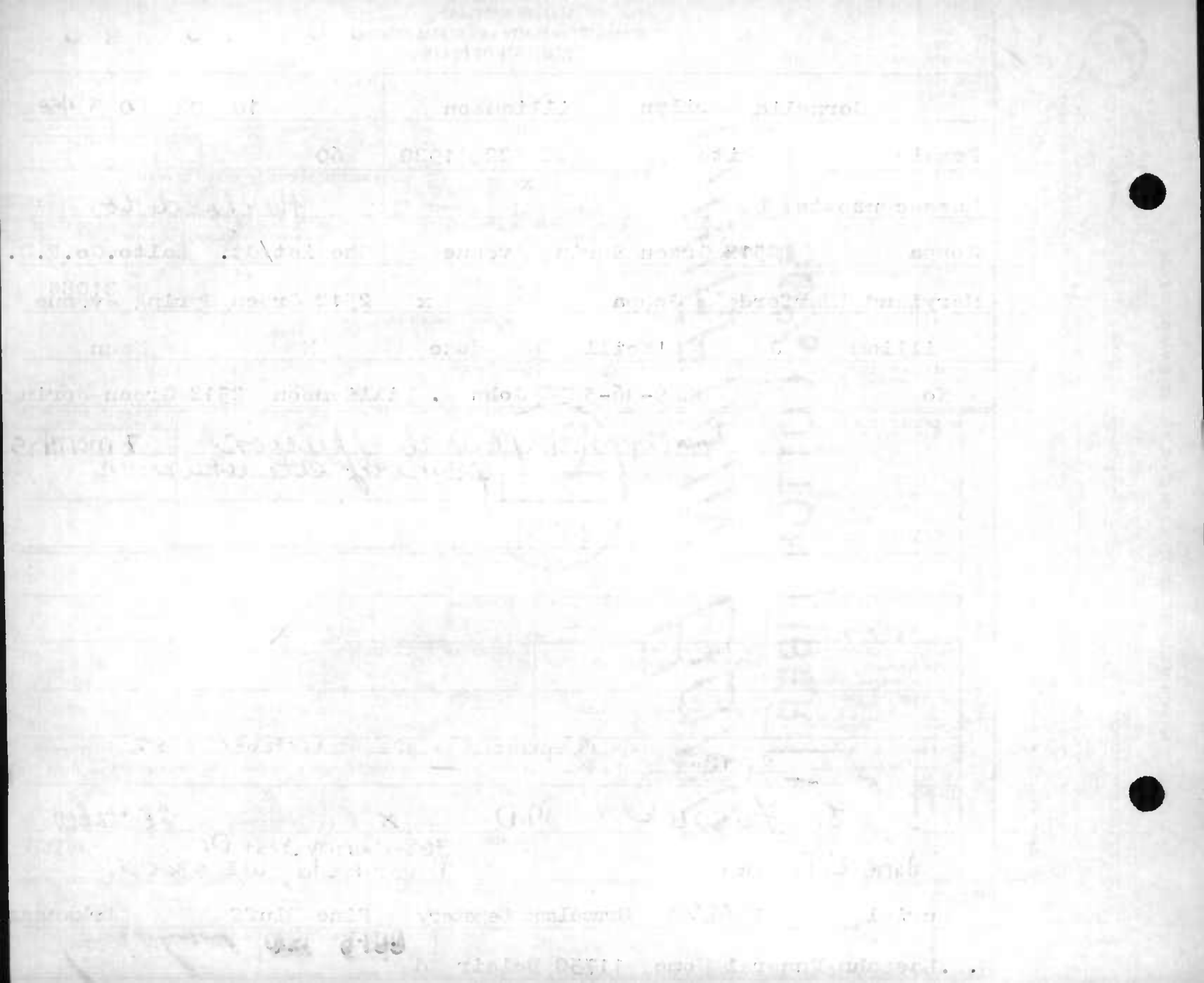
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH : 16 25M

(VR A 15 (4) 9/74



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DHMM-16 30M 2/80
(VRA 15, 4)

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE CAROLYN LAST Wrigley			2a. DATE OF DEATH MONTH DAY YEAR Oct 28 80		2b. HOUR 5:15 P M
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 3 20 1926	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARford MD.		
10. CITY OR TOWN OF DEATH HAYRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Transcriber	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. STATE MD.			13b. COUNTY HARford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Eugene F. Wrigley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Flynn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 290-24-0506	17. INFORMANT ADDRESS Aberdeen, Md. 21001 Rose F. Dargan, Apt. 17A, 309 S. Parke St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) C.O.P.D. and DUE TO, OR AS A CONSEQUENCE OF (c) A.S. C.V.D. Sudden years 2-3 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Oct 28th 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.		22c. DATE SIGNED 10/28/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D.		22e. ADDRESS HAYRE de GRACE, Ind. 21078		22f. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/80		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland		23e. DATE REC'D. BY REGISTRAR NOV 3 1980		23f. REGISTRAR'S SIGNATURE Dorothy McHenry	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001					



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